- Healthy eating articles
- Lose weight articles
- Mental health articles
- Pain articles
- Pregnancy articles
- Sexual health articles
- Stop smoking articles
- Vaccinations articles
- Winter health articles
- Health check tools
- All Live Well

- Carers Direct
  - Help for those looking after others
  - Guide to caring
  - Money and legal
  - Work and learning
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- Stop smoking
- Walk-in centres
- All directories

You are here:

- The NHS in England
- Healthcare abroad
- European Health Insurance Card

European Health Insurance Card

- Free EHIC
- Applying and renewing
- Using an EHIC
- What's covered?
- EU regulations

- European Health Insurance Card

About the EHIC



The European Health Insurance Card (EHIC) allows you to access state-provided healthcare in all European Economic Area (EEA) countries and Switzerland at a reduced cost or sometimes free of charge.

Everyone who is resident in the UK should have one and carry it with them when travelling abroad. Remember to check your EHIC is still valid before you travel. **Applying for the card is free** and it's valid for up to five years.

Presenting the EHIC entitles you to treatment that may become necessary during your trip, but doesn't allow you to go abroad specifically to receive medical care. However, maternity care, renal dialysis and managing the symptoms of pre-existing or chronic conditions that arise while abroad are all covered by the EHIC.

Your EHIC will allow you access to the same state-provided healthcare as a resident of the country you are visiting. However, many countries expect the patient to pay towards their treatment, and even with an EHIC,

you might be expected to do the same. You may be able to seek reimbursement for this cost when you are back in the UK if you are not able to do so in the other country.



The EHIC is NOT an alternative to travel insurance. It will not cover any private medical healthcare or the cost of things such as mountain rescue in ski resorts, repatriation to the UK or lost or stolen property.

For these reasons and others, it is important to have both an EHIC and a valid private travel insurance policy. Some insurers now insist you hold an EHIC and many will waive the excess if you have one.

Applying for an EHIC is easy. Even if you don't have any plans to travel in the near future, it is always a good idea to get one.

Renew or apply for your free EHIC now.

EHIC 1

See what can happen if you go on holiday without a
European Health Insurance Card (EHIC)

Comments

1 Comments about ‘About the EHIC’

Our rules:

Little mama said on 14 February 2011

Just want to thank the team for such a fantastic service. Ordered cards Thursday received on following Monday. Thank you!

Report this content as offensive or unsuitable comment id 12372

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Next review due: 29/04/2011

Contacts

Apply for an EHIC online https://www.ehic.org.uk/

For difficulties with the online application form, call the automated service on **0845 606 2030**.

Replace a lost or stolen card while you are abroad, claim refunds or for general enquiries about the EHIC call the Overseas Healthcare Team
on **0044 (0)191 218 1999**

To update your personal details, call the EHIC enquiries team on **0845 605 0707,**
if calling from abroad **0044 191 212 7500**

Useful links

NHS Choices links

- Moving abroad
- Planned treatment abroad
- Country-by-country guide
- Health A-Z: altitude sickness
- Health A-Z: insect bites
- Health A-Z: malaria
- Health A-Z: travel health
- Health A-Z: travel sickness
- Health A-Z: travel vaccinations
- Health A-Z: travellers' diarrhoea
- Live Well: travel health
- Live Well: gap year health
- Videos: travel

External links

- MDtravelhealth.com

- fitfortravel
- FCO: travel advice
- MASTA
- NHS European Office - Healthcare in the EU



When and where to get your travel jabs

Find out where to get travel vaccinations, including your GP surgery or high street travel vaccination clinics. Plus tips on how to prepare for travel jabs.

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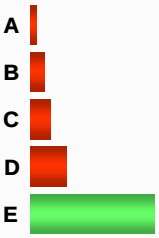
Question 14 of 184

One of your GP colleagues asks you what revalidation will mean for her. What will revalidation assess?

- A. Fitness to hold a medical licence + suitability of current career choice
- B. Fitness to hold a medical licence + fitness to be on the GP Register + suitability of current career choice
- C. Fitness to be on the GP Register
- D. Fitness to hold a medical licence
- ✓ E. Fitness to hold a medical licence + fitness to be on the GP Register

Next question

Question stats



62.9% of users answered this question correctly

Session score = 7.1%

Revalidation

Revalidation introduces a change in the way doctors are licensed and certificated. Currently UK doctors automatically receive their licence to practise if they have paid their annual fee and have no limitations on their registration (e.g. Following a GMC ruling). To practise as a GP doctors must also be on the GP Register - a process known as certification.

Following the introduction of revalidation doctors will be required to prove their fitness to practise to allow them to continue to work as a doctor. Revalidation will occur every 5 years and in one process combine relicensing and recertification. Annual appraisals will continue as before but there will be a focus on whether the doctor is making sufficient progress towards their revalidation portfolio.

The type and amount of evidence required will be similar to that needed for appraisals currently. The RCGP is creating an ePortfolio for the process and proposes that it should contain the following (please see the link for more details):

- description of your work
- description of any special circumstances (e.g. Prolonged illness)
- details of previous appraisals
- current personal development plan
- review of previous personal development plans
- evidence of continuing professional development - at least 50 'learning credits' are required per year
- multi-source feedback
- patient questionnaire surveys
- significant event audits
- review of any formal complaints
- probity/health statements

Learning credits

RCGP curriculum

3.1 - Clinical Governance

Curriculum statement

External links

RCGP
Revalidation

- minimum of 1 credit for each hour of education
- however, if the hour of education can be shown to lead to improvements in patient care then it will count as 2 credits

Submitting the evidence for revalidation

- the ePortfolio will be submitted electronically for review
- the review will be done by a 'Responsible Officer'
- the Responsible Officer is likely to be advised by a GP assessor and a trained lay person
- if the submitted evidence is considered sufficient the Responsible Officer will recommend to the GMC that the doctor is both relicensed and recertificated

Revalidation is due to be phased in from 2011 to 2016.

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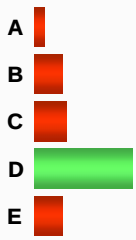
Question 6 of 188

Which one of the following is not a principle of the 1998 Data Protection Act?

- A. Individuals have a right of access to the information held about them
- B. Patients have the right to have factually incorrect information about them corrected
- C. Personal information may be kept for no longer than is necessary and must be kept up-to-date
- ✓ D. Entities which hold personal data must appoint a Data Protection Registrar to ensure the principles of the Act are implemented
- E. Data must be used for the specific purpose it was collected

Next question

Question stats



50.4% of users answered this question correctly

Session score = 0%

Data Protection Act

The 1998 Data Protection Act is the main piece of legislation that governs the protection of personal data in the UK. The Act covers both manual and computerised records.

There are 8 main principles of the Data Protection Act:

- data must be used for the specific purpose it was collected
- data must not be disclosed to other parties without the consent of the individual whom it is about
- individuals have a right of access to the information held about them
- personal information may be kept for no longer than is necessary and must be kept up-to-date
- personal information may not be transmitted outside the European Union unless consent has been given
- all entities (e.g. a GP surgery) that process personal information must register with the Information Commissioner's Office
- adequate security measures must be in place. Those include technical measures (e.g. passwords, firewalls) and organisational measures (e.g. staff training)
- subjects (i.e. patients) have the right to have factually incorrect information about them corrected

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

External links

Information Commissioner's Office
Guidelines on recording opinions

Rate question:

Next question

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Question 7 of 188

Which one of the following best describes the General Medical Services contract?

- A. Nationally agreed, locally managed contract between a General Practitioner and the local primary care trust
- B. Nationally agreed, locally managed contract between a Practice and the Department of Health
- ✓ C. Nationally agreed, locally managed contract between a Practice and the local primary care trust
- D. Locally agreed, locally managed contract between a Practice and the local primary care trust
- E. Locally agreed, locally managed contract between a General Practitioner and the local primary care trust

Next question

GMS - nationally agreed, locally managed contract between a Practice and the local primary care trust

GP contract: GMS contract

A General Medical Services (GMS) contract is made between a Practice and the local primary care trust

Key elements

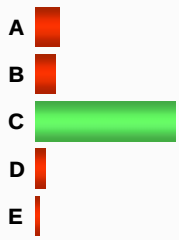
- a nationally agreed, locally managed contract
- describes services provided by the Practice, divided into essential, additional and enhanced (see below)

Essential services	Additional services	Enhanced services
• Day-to-day medical care • Management of patients who are terminally ill • Chronic disease management	• Contraception services • Vaccination services • Cervical screening • Child health surveillance • Maternity services • Minor surgery	• Directed enhanced services • National enhanced services • Local enhanced services

Examples of Directed Enhanced Services (DES)

- Learning Disabilities DES - annual health checks for people on the local authority learning disability register. To participate in this DES, practices

Question stats



71.1% of users answered this question correctly

Session score = 0%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

need to attend a multi professional education session run by their PCT. Practices will get £100 for every health check

- Heart Failure DES - improving the treatment of heart failure and including incentives to provide beta-blockers to appropriate patients. Practices will get £35 per patient treated under this DES.

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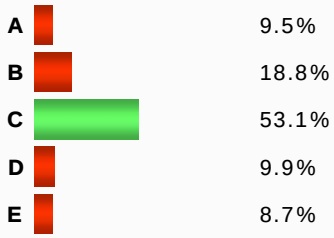
Question 8 of 188

With reference to the Quality and Outcomes Framework (QOF), which component is responsible for the second highest number of points?

- A. Child health surveillance
- B. Clinical indicators
- ✓ C. Organisational
- D. Additional services
- E. Patient experience

Next question

Question stats



53.1% of users answered this question correctly

Session score = 0%

Quality and Outcomes Framework

The Quality and Outcomes Framework (QOF) is the annual reward and incentive programme detailing GP practice achievement results. It was introduced as part of the new General Medical Services (GMS) to incentivise not only the management of chronic disease such as diabetes but also to improve the organisation of the practice and patient experience

Other points

- for clinical indicators the value of a point is determined by the prevalence of that condition in the practice
- participation in the QOF is voluntary
- 5% of practices should be visited at random to help prevent fraud. The PCT visiting team will normally consist of a PCT management representative, a GP and a patient representative

The table below shows the four key areas on which the QOF is based

Clinical indicators	697 points	Standards linked to the care of patients suffering from chronic diseases
Organisational	167.5 points	Standards relating to records and information, communicating with patients, education and training, medicines management and clinical and practice management
Additional services	44 points	Covering cervical screening, child health surveillance, maternity services and contraceptive services
Patient experience	91.5 points	Based on patient surveys and length of consultations

Patients may be 'exception reported' in the following situations:

- patients who have been recorded as refusing to attend review who have

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

been invited on at least three occasions during the preceding 12 months
- patients for whom it is not appropriate to review the chronic disease parameters due to particular circumstances e.g. Terminal illness, extreme frailty
- patients newly diagnosed within the practice or who have recently registered with the practice, who should have measurements made within 3 months and delivery of clinical standards within 9 months e.g. Blood pressure or cholesterol measurements within target levels
- patients who are on maximum tolerated doses of medication whose treatment remain sub-optimal
- patients for whom prescribing a medication is not clinically appropriate e.g. Those who have an allergy, another contraindication or have experienced an adverse reaction
- where a patient has not tolerated medication
- where a patient does not agree to investigation or treatment (informed dissent), and this has been recorded in their medical records
- where the patient has a supervening condition which makes treatment of their condition inappropriate e.g. Cholesterol reduction where the patient has liver disease
- where an investigative service or secondary care service is unavailable

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Questions 9 to 11 of 188

Theme: Benefits

A Bereavement Allowance
B Bereavement Payment
C Statutory Sick Pay
D Disability Living Allowance
E Employment and Support Allowance
F State pension
G Income Support
H Job Seekers Allowance
I No benefits claimable

For each of the following scenarios select the claimable benefit

9. 20-year-old man with severe autism who needs carers to help him with personal care

Bereavement Allowance

The correct answer is Disability Living Allowance

10. 56-year-old council worker who has not been working for 10 months due to back pain

Bereavement Allowance

The correct answer is Employment and Support Allowance

Employment and Support Allowance replaced Incapacity Benefit for new claimants from October 2008

11. Lump sum payment for a 55-year-old woman whose husband has just died

Bereavement Allowance

The correct answer is Bereavement Payment

Next question

Question stats

Average score for registered users:

9	90.9%
10	40.4%
11	76.6%

Session score = 0%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

Benefits

Whilst GPs are not supposed to be experts on claimable benefits, a rough understanding is expected

Income support	Aged 16-59 years, on low income, working less than 16 hours per week and not receiving Job Seekers Allowance
Job Seekers Allowance	From 19 years old to state pension age. Claimants must be capable of working and agree to actively seek work
Disability Living Allowance	Tax-free benefit for children and adults who need help with personal care or have walking difficulties because they are physically or mentally disabled
Statutory Sick Pay	For employees unable to work due to illness. Unable to work for > 4 days in a row. Paid up to a maximum of 28 weeks
Incapacity Benefit & Employment and Support Allowance	Employment and Support Allowance replaced Incapacity Benefit for new claimants from October 2008. Claimable by those not entitled to Statutory Sick Pay (SSP), for example self-employed, or when SSP has ended
Retirement pension	State pension may be claimed from 60 years for women and 65 years for men. State pensions are taxable and paid even if the claimant is still working
Bereavement payment	Lump sum given to spouse if they are under state pension age when their partner died Depends on national insurance contributions Not payable to divorcees
Bereavement allowance	Taxable weekly benefit paid to the spouse for up to 52 weeks from the date of death, if the surviving partner is 45 years or older and less than the state pension age
Health in Pregnancy Grant	Payable to pregnant women between the 25th week of pregnancy and expected date of delivery. One-off lump sum, patients need form signing by midwife or doctor. Due to be scrapped from the 1st January 2011.

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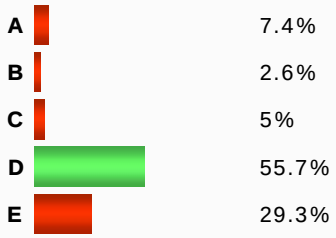
Question 12 of 188

Which one of the following is a valid reason for exception reporting a patient under the quality and outcomes framework (QOF)?

- A. A patient who is housebound
- B. A patient who lives more than 3 miles from the practice
- C. A patient who has a chaotic lifestyle such as an intravenous drug user
- ✓ D. A patient who registered to the practice 2 months ago
- E. A patient who has refused to attend surgery on two separate occasions in the past 12 months

Next question

Question stats



55.7% of users answered this question correctly

Session score = 0%

Quality and Outcomes Framework

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

The Quality and Outcomes Framework (QOF) is the annual reward and incentive programme detailing GP practice achievement results. It was introduced as part of the new General Medical Services (GMS) to incentivise not only the management of chronic disease such as diabetes but also to improve the organisation of the practice and patient experience

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- where the patient has a supervening condition which makes treatment of their condition inappropriate e.g. Cholesterol reduction where the patient has liver disease
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Question 13 of 188

Eight doctors meet to discuss 'problem' patients on an informal basis. They take it in turns to talk about why they find the patient difficult to deal with. Following this the other doctors discuss aspects of the doctor-patient relationship. Which one of the following does this best describe?

- A. Balint group
- B. RCGP feedback model
- C. Pendleton discussion
- D. Fraser meeting
- E. Neighbour group

Next question

Question stats

A	72.2%
B	7.6%
C	9.2%
D	5.2%
E	5.8%

72.2% of users answered this question correctly

Session score = 0%

Balint groups

Michael Balint (1896-1970) was a Hungarian psychoanalyst and psychiatrist who shaped many of the modern views on patient centred healthcare. He was primarily interested in the psychological and emotional problems that underlie many presenting complaints. His work encouraged GPs to explore these areas to understand their patients better. Balint coined the phrase 'the doctor as a drug'.

During the 1950's he established small, groups ('Balint Groups') which allowed GPs to discuss their patients on an informal basis. These are not dissimilar to discussions held amongst GP Registrars during their half-day release.

Balint's ideas were published in the book 'The doctor, his patient and the illness'.

RCGP curriculum

2 - The General Practice Consultation

Curriculum statement

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Question 14 of 188

You receive a phone call from one of your patients who is abroad. He is 60-years-old and has just been discharged following admission to a Spanish hospital after suffering a myocardial infaction. There were no reported complications and he did not undergo a percutaneous coronary intervention. How soon after the myocardial infarction can he fly home?

- A. After 3-5 days
- B. After 14 days
- C. After 4 weeks
- D. After 48 hours if no further chest pain
- ✓ E. After 7-10 days

Next question

Fitness to fly - MI - after 7-10 days

Question stats

A	7.8%
B	12.1%
C	18%
D	10.6%
E	51.5%

51.5% of users answered this question correctly

Session score = 0%

External links

Civil Aviation Authority
Fitness to fly guidelines

Fitness to fly

The Civil Aviation Authority (CAA) has issued guidelines on air travel for people with medical conditions; please see the link provided.

Cardiovascular disease

- unstable angina, uncontrolled hypertension, uncontrolled cardiac arrhythmia, decompensated heart failure, severe symptomatic valvular disease: should not fly
- uncomplicated myocardial infarction: may fly after 7-10 days
- complicated myocardial infarction: after 4-6 weeks
- coronary artery bypass graft: after 10-14 days
- percutaneous coronary intervention: after 5 days

Respiratory disease

- pneumonia: should be 'clinically improved with no residual infection'
- pneumothorax: absolute contraindication, the CAA suggest patients may travel 2 weeks after successful drainage if there is no residual air. The British Thoracic Society used to recommend not travelling by air for a period of 6 weeks but this has now been changed to 1 week post check x-ray

Pregnancy

- most airlines do not allow travel after 36 weeks for a single pregnancy and after 32 weeks for a multiple pregnancy

- most airlines require a certificate after 28 weeks confirming that the pregnancy is progressing normally

Surgery

- travel should be avoided for 10 days following abdominal surgery
- laparoscopic surgery: after 24 hours
- colonoscopy: after 24 hours
- following the application of a plaster cast, the majority of airlines restrict flying for 24 hours on flights of less than 2 hours or 48 hours for longer flights

Haematological disorders

- patients with a haemoglobin of greater than 8 g/dl may travel without problems (assuming there is no coexisting condition such as cardiovascular or respiratory disease)

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Question 15 of 188

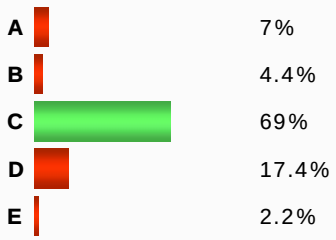
Which one of the following consultation models advocates finding out the reason for the patient's attendance in terms of ideas, concerns and expectations?

- A. Stott and Davis
- B. Stewart
- ✓ C. Pendleton
- D. Neighbour
- E. Tuckett

Next question

There are also elements of exploring ideas, concerns and expectations in the Calgary-Cambridge model.

Question stats



69% of users answered this question correctly

Session score = 6.7%

RCGP curriculum

2 - The General Practice Consultation

Curriculum statement

Consultation models

Calgary-Cambridge observation guide- Kurtz and Silverman - 1996

- initiating the session
- gathering information
- building the relationship
- giving information, explaining and planning
- closing the session

Stewart - patient-centred clinical method - 1995. 2003

- exploring both the disease and the illness experience
- understanding the whole person
- finding common ground
- incorporating prevention and health promotion
- enhancing the doctor-patient relationship
- being realistic (with time and resources)

Pendleton - The Consultation: an Approach to Learning and Teaching - 1984, 2003

- define the reason for the patient's attendance (ideas, concerns and expectations)
- consider other problems
- with the patient, choose an appropriate action for each problem
- achieve a shared understanding of the problems with the patient
- involve the patient in the management and encourage him/her to accept appropriate responsibility
- use time and resources appropriately
- establish or maintain a relationship with the patient which helps to achieve the other tasks

Fraser - Areas of competence - 1992

- interviewing and history-taking
- physical examination
- diagnosis and problem-solving
- patient management
- relating to patients
- anticipatory care
- record keeping

Neighbour - The Inner Consultation - five checkpoint model - 1987

- connecting
- summarising
- handing over
- safety netting
- housekeeping

Tuckett - meeting of two experts - 1985

- the consultation is a meeting between two experts
- doctors are experts in medicine
- patients are experts in their own illnesses
- shared understanding is the aim
- doctors should seek to understand the patient's beliefs
- doctors should address explanations in terms of the patient's belief system

Stott and Davis - Exceptional potential of the consultation - 1979

- management of presenting problems
- management of continuing problems
- modification of help-seeking behaviour
- opportunistic health promotion

Rate question:

Next question

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Question 16 of 188

Which one of the following statements regarding appraisal is incorrect?

- A. The appraiser may be a non-principal
- B. Formal training is required to become an appraiser
- C. It is compulsory
- D. The average time commitment for appraisal is a minimum of 4.5 to 6.5 hours
- E. Practices are responsible for funding locum cover

Next question

Primary care trusts are responsible for funding locum cover to compensate for time lost to appraisals

Question stats

A	10.2%
B	5.8%
C	6.5%
D	26.8%
E	50.7%

50.7% of users answered this question correctly

Session score = 6.3%

Appraisal

Appraisal has been a requirement for GPs since 2002. It is meant to be a formative process identifying development needs rather than performance management.

Appraisal will eventually provide a regular, structured system for recording progress
towards revalidation and identifying development needs

The appraiser should be another GP (principal or non-principal), who will have been properly trained in appraisal. Typically the average time commitment for appraisal is a minimum of 4.5 to 6.5 hours. This includes between 2 and 4 hours for preparation. Primary Care Trusts should provide funds for locum cover to compensate for this time

The content of appraisal is based on the core headings set out in the GMC's Good Medical Practice document:

- good clinical care
- maintaining good medical practice
- relationships with patients
- working with colleagues
- teaching and training
- probity
- health

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

Rate question:

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Question 17 of 188

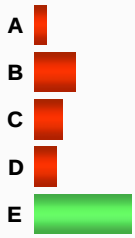
The District Nurse requests a prescription for a syringe driver. This is for a patient you saw earlier in the day who is dying of metastatic renal cancer. You would like her to receive 60mg of diamorphine over a 24 hour period. Which one of the following is the correct wording of the prescription?

- A. 180mg of diamorphine in 6 ampoules. 60mg (sixty milligrams) daily by subcutaneous infusion over 24 hours.
- B. Diamorphine 30mg ampoules. Supply 6 ampoules. 60mg (sixty milligrams) daily by subcutaneous infusion over 24 hours.
- C. Diamorphine 30mg (thirty milligrams) ampoules. Supply 6 ampoules. 60mg daily by subcutaneous infusion over 24 hours.
- D. 180mg of diamorphine in 6 (six) ampoules. 60mg daily by subcutaneous infusion over 24 hours.
- ✓ E. Diamorphine 30mg ampoules. Supply 6 (six) ampoules. 60mg daily by subcutaneous infusion over 24 hours.

Next question

Controlled drugs - it is the quantity supplied which needs to be stated in both figures and words, rather than the dosage

Question stats



49.3% of users answered this question correctly

Session score = 5.9%

RCGP curriculum

3.2 - Patient Safety

Curriculum statement

External links

UK Government
Misuse of Drugs Regulations 2001

Controlled drugs

When prescribing a controlled drug the following must be present on the prescription:

- name and address of the patient
- the form, and where appropriate the strength, of the preparation

- either the total quantity (in both words and figures) of the preparation, or the number (in both words and figures) of dosage units to be supplied

- the dose (cannot write 'as directed')
- prescribers name, signature, address and current date

The 2001 Misuse of Drugs Regulations act defines who is authorised to prescribe controlled drugs. It divided drugs of potential abuse into 5 categories ('schedules') each with own rules on prescribing, supply, possession, record keeping etc

Schedule 1	Cannabis, lysergide
Schedule 2	Diamorphine, morphine, pethidine, amphetamine, cocaine
Schedule	Barbiturates, buprenorphine, midazolam*, temazepam**

3	
Schedule 4	**Part 1**: Benzodiazepines (except midazolam and temazepam) and zolpidem **Part 2**: Androgenic and anabolic steroids, hCG, somatropin Controlled drug prescription requirements do not apply and Schedule 4 controlled drugs are not subject to safe custody requirements
Schedule 5	Includes preparations which because of their strength are exempt from the vast majority of Controlled Drug requirements other than retention of invoices (e.g. Oramorph 10mg/5ml)

Further selected points

- Schedule 2 and 3 drugs are marked 'CD' in the BNF
- a prescription for controlled drugs in Schedules 2,3 & 4 is valid for 28 days
- a pharmacist is generally not allowed to dispense unless all the information required by law is given. With Schedule 2 and 3 drugs a pharmacist is allowed to amend the prescription if 'it specifies the total quantity only in words or in figures or if it contains minor typographical errors, provided that such amendments are indelible and clearly attributable to the pharmacist making them'

*midazolam was changed from schedule 4 to 3 in 2008

**temazepam is excluded from the prescription requirements

Rate question:

Next question

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Question 18 of 188

A 35-year-old patient who you have known for five years requests antibiotics for a suspected urinary tract infection (UTI) during a telephone consultation. She reports a two day history of dysuria and frequency and had a proven UTI last year with identical symptoms. According to GMC guidance what is the most appropriate action?

- ✓ A. Antibiotics can be prescribed, with normal safeguards and advice
- B. If the patient cannot be persuaded to come in then antibiotics can be prescribed
- C. If the patient has been seen in the past 3 months then antibiotics can be prescribed, with normal safeguards and advice
- D. Antibiotics should not be prescribed during a telephone consultation
- E. Advise the patient to phone NHS direct

Next question

Question stats

A	66.9%
B	13.2%
C	8.6%
D	11%
E	0.3%

66.9% of users answered this question correctly

Session score = 11.1%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

External links

GMC
Good Practice in Prescribing Medicines

The GMC guidance allows for telephone prescribing as long as normal safeguards are adhered to

GMC guidance: Good Practice in Prescribing Medicines

Good Practice in Prescribing Medicines was published in 2008. A link is provided to the full guidance, below is only selected highlights:

Principles of prescribing

- doctors with full registration may prescribe all medicines, but not those drugs in Schedule 1 of the Misuse of Drugs Regulations 2001
- you should only prescribe drugs to meet identified needs of patients and never for your own convenience or simply because patients demand them
- avoid treating yourself and those close to you

Keeping up to date and prescribing in patients' best interests

- the guidelines make specific mention of the BNF, NICE and SIGN
- you should inform the Committee on the Safety of Medicines of adverse reactions to medicines reported by your patients in accordance with the Yellow Card Scheme
- if you prescribe at the recommendation of a nurse or other healthcare professional who does not have prescribing rights, you must be satisfied that the prescription is appropriate for the patient concerned and that the professional is competent to have recommended the treatment

Doctors' interests in pharmacies

- you should ensure that your patients have access to information about your own and (where known) your employers' financial or commercial interests in any pharmacy they are likely to use

Prescribing controlled drugs for yourself or someone close to you

- doctors should, wherever possible, avoid treating themselves or anyone with whom they have a close personal relationship and should be registered with a GP outside their family
- you should not prescribe a controlled drug for yourself or someone close to you unless no other person with the legal right to prescribe is available to assess the patient's clinical condition and to prescribe without a delay which would put the patient's life or health at risk, or cause the patient unacceptable pain, and that treatment is immediately necessary to save life, avoid serious deterioration in the patient's health or alleviate otherwise uncontrollable pain

Remote prescribing via telephone, email, fax, video link or a website

- this is supported in the guidelines with obvious caveats
- if you are 'not providing continuing care for the patient', for example doing out-of-hours the guidelines recommend giving an explanation to the patient of the processes involved in remote consultations and giving your name and GMC number to the patient

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Question 19 of 188

You are a GP registrar. You receive a letter from an orthopaedic consultant after referring a 60-year-old man with right knee osteoarthritis. He is annoyed you discussed the possibility of a knee replacement with the patient saying that this is not yet indicated and adding that it 'made my discussions with the patient most difficult'. He advises 'it would be better if I stick to my job and you stick to yours'. How should you respond to this?

- A. Write a reply to the consultant saying that you were disappointed by the tone of his letter and felt discussing knee replacement was appropriate
- B. Write a letter stating that you will not refer patients to him on a private basis unless he writes you a letter of apology
- C. Write a letter of apology to the consultant
- D. Call the patient in, explain the contents of the letter and advise the patient to switch consultants
- E. Take no action

Next question

Question stats

A	76.5%
B	0.5%
C	9.7%
D	0.9%
E	12.4%

76.5% of users answered this question correctly

Session score = 10.5%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

It is not unreasonable to discuss potential secondary care management with a patient and in many ways is good practice. The letter from the consultant is therefore inappropriate.

The professional approach would therefore be to write a polite letter explaining your point of view. Accepting that the colleague is rude is a poor option as the consultant may not genuinely understand the role of General Practice. Apologising is a poor option as it will simply perpetuate such behaviour.

Trying to get the patient on ‘your side’ interferes with patient care and is unprofessional. Effectively blackmailing the consultant is also a bad idea!

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Rate question:

Next question

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Questions 20 to 22 of 188

Theme: DVLA: neurological disorders

A No restriction
B No restriction but inform DVLA
C 1 month off
D 3 months off
E 6 months off
F 12 months off
G Once satisfactory control of symptoms

For each of the following scenarios select the most appropriate advice regarding driving:

20. Stroke - satisfactory clinical recovery

1 month off

21. Transient ischaemic attack - single episode

1 month off

22. Unexplained syncope. Second episode in past 2 months. Under investigation by cardiologist for abnormal echocardiogram

6 months off

If low risk of recurrence then only restricted for 4 weeks

Next question

Question stats

Average score for registered users:

20	68.1%
21	74.9%
22	35.9%

Session score = 22.7%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

External links

DVLA
Neurological disorder guidelines

DVLA: neurological disorders

The guidelines below relate to car/motorcycle use unless specifically stated. For obvious reasons, the rules relating to drivers of heavy goods vehicles tend to be much stricter

Specific rules

- first seizure: 6 months off driving*. For patients with established epilepsy they must be fit free for 12 months before being able to drive
- stroke or TIA: 1 month off driving
- multiple TIAs over short period of times: 3 months off driving
- craniotomy e.g. For meningioma: 1 year off driving**
- pituitary tumour: craniotomy: 6 months; trans-sphenoidal surgery 'can drive when there is no debarring residual impairment likely to affect safe driving'
- narcolepsy/cataplexy: cease driving on diagnosis, can restart once 'satisfactory control of symptoms'

Syncope

- simple faint: no restriction
- unexplained, low risk of recurrence: 4 weeks off
- explained and treated: 4 weeks off
- unexplained: 6 months off

*previously rule was 12 months. It is now 6 months off driving if the licence holder has undergone assessment by an appropriate specialist and no relevant abnormality has been identified on investigation, for example EEG and brain scan where indicated

**if the tumour is a benign meningioma and there is no seizure history, licence can be reconsidered 6 months after surgery if remains seizure free

Rate question:

Next question

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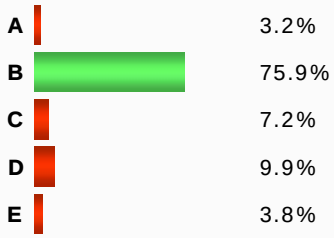
Question 23 of 188

A 68-year-old woman who has recently been diagnosed with metastatic pancreatic cancer presents for review. She has heard she may be eligible for benefits to help with personal care. What is the most appropriate form to fill in?

- A. SF300
- ✓ B. DS1500
- C. Incapacity Benefit form
- D. Disability Living Allowance form
- E. SC1

Next question

Question stats



75.9% of users answered this question correctly

Session score = 21.7%

As this patient has a poor prognosis her application for attendance allowance (not Disability Living Allowance as she is over 65 years) should be fast-tracked using the DS1500 form

The SF300 is a form used by people applying for a Community Care Grant

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

Benefits: chronic illness and cancer patients

Patients who have a chronic illness or cancer, which results in a disability severe enough to need help with caring for themselves, are entitled to claim the following benefits:

- Disability Living Allowance: for patients under the age of 65 years
- Attendance Allowance: for patients over aged 65 years and over

Disability Living Allowance

Disability Living Allowance (DLA) can be claimed by patients who normally have needed help for at least 3 months and be likely to need it for at least a further 6 months. It is tax-free, not means tested and divided into two components:

- Care component
- Mobility component

Attendance Allowance

Attendance Allowance (AA) is a tax-free allowance for people aged 65 or over when they claim who need help with their personal care. To claim AA patients should normally have needed help with care for 6 months. Like DLA it is not means tested

Terminally ill patients

Patients who have a terminal illness (where there is an expectation that the patient will not live for more than 6 months) are eligible to be fast-tracked through the system for claiming DLA or AA. A **DS1500** form is completed which

ensures the application is dealt with promptly and that the patient automatically receives the higher rate

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Question 1 of 165

Which one of the following drugs should be prescribed using the proprietary, rather than the generic name?

- A. Paroxetine
- B. Clozapine
- C. Lofepramine
- ✓ D. Carbamazepine
- E. Sumatriptan

Next question

Question stats

A	6.2%
B	25.1%
C	7.9%
D	49.9%
E	10.9%

49.9% of users answered this question correctly

Session score = 0%

Prescribing guidance

The BNF issues guidance on good practice when prescribing, selected points include:

- drugs should generally be prescribed by their generic name, except for certain preparations where the clinical effect may differ - please see the list below
- when writing numbers unnecessary decimal points should be avoided e.g. 250 ml not 0.25 l

Drugs which should be prescribed by brand

- modified release calcium channel blockers
- antiepileptics
- ciclosporin and tacrolimus
- mesalazine
- lithium
- aminophylline and theophylline
- methylphenidate
- CFC-free formulations of beclometasone
- dry powder inhaler devices

RCGP curriculum

3.2 - Patient Safety

Curriculum statement

Rate question:

Next question

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Question 2 of 165

A 15-year-old boy from Birmingham is brought to surgery by his mother complaining of abdominal pains for the past two days. On examination there is a clinical suspicion of appendicitis and a referral to hospital is planned. On discussing this with the patient he refuses to be admitted as he had planned to go to a party tonight. He is able to understand all information you give him and repeat it, including the serious nature of untreated appendicitis. What is the most appropriate course of action?

- A. An independent legal guardian should be appointed
- B. As he has demonstrated capacity his wishes should be respected
- C. An approved social worker should be contacted
- D. A psychiatric opinion is mandatory before further management
- ✓ E. His mother may overrule his wishes

Next question

Question stats

A	1.2%
B	24.3%
C	1.4%
D	0.5%
E	72.7%

72.7% of users answered this question correctly

Session score = 0%

In England and Wales a child has the ability to consent to, but not refuse, treatment. Whether a child has demonstrated capacity (as per the Fraser guidelines) is not the relevant issue.

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

Consent: children

The General Medical Council have produced guidelines on obtaining consent in children:

- at 16 years or older a young person can be treated as an adult and can be presumed to have capacity to decide
- under the age of 16 years children may have capacity to decide, depending on their ability to understand what is involved
- where a competent child refuses treatment, a person with parental responsibility or the court may authorise investigation or treatment which is in the child's best interests*

External links

General Medical Council Consent guidelines

With regards to the provision of contraceptives to patients under 16 years of age the Fraser Guidelines state that all the following requirements should be fulfilled:

- the young person understands the professional's advice
- the young person cannot be persuaded to inform their parents
- the young person is likely to begin, or to continue having, sexual intercourse with or without contraceptive treatment
- unless the young person receives contraceptive treatment, their physical or mental health, or both, are likely to suffer
- the young person's best interests require them to receive contraceptive advice or treatment with or without parental consent

Gillick or Fraser?

Some doctors use the term Fraser competency when referring to contraception

and Gillick competency when referring to general issues of consent in children. The (widespread) rumours that Victoria Gillick removed her permission to use her name or applied copyright have recently been debunked.

More information can be found in the following article:

Wheeler R. Gillick or Fraser? A plea for consistency over competence in children BMJ 2006;332:807

*in Scotland those with parental responsibility cannot authorise procedures a competent child has refused

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Next question

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Question 3 of 165

You are a GP registrar. Whilst parking at the surgery you notice a 34-year-old epileptic man also parking in the patient's car park. He has an appointment with you this morning. You know from previous consultations that his last fit was 7 months ago. During the consultation the patient denies driving. What is the most appropriate action?

- A. Take the patient at their word and take no further action
- ✓ B. Inform him of the DVLA rules and your duty to inform the DVLA if he refuses to stop
- C. Inform the DVLA immediately after telling the patient what you are going to do
- D. Inform the DVLA anonymously to maintain the doctor-patient relationship
- E. Confiscate his car keys during the consultation to prevent danger to the public

Next question

You have seen the patient drive yourself so it is wrong to simply ignore the situation. The best option is to inform him of the DVLA rules and your duty to notify the DVLA is he refuses to stop. Informing the DVLA immediately is not the best option as it does not allow the patient to rectify the situation themselves and may damage your long term relationship. It is always better to be honest and open with patients about your actions.

Confiscating the patient's keys is impractical and likely to lead to confrontation.

Please note that the new '6 month rule' only applies following a first fit which has been investigated, rather than to patients with existing epilepsy.

_

Rate question:

Next question

Comment on this question

Question stats

A	0.8%
B	89.7%
C	8.9%
D	0.4%
E	0.2%

89.7% of users answered this question correctly

Session score = 0%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

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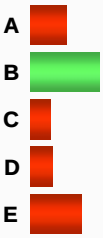
Question 4 of 165

You are counselling the wife of a man who has died unexpectedly of a myocardial infarction. Two weeks after his death she mentions some financial problems she is having. Which one of the following determines whether she qualifies for the Bereavement Payment?

- A. No qualifying criteria
- ✓ B. Age < 65 years + national insurance contributions
- C. Age > 65 years + national insurance contributions
- D. National insurance contributions
- E. Age < 65 years

Next question

Question stats



35.1% of users answered this question correctly

Session score = 0%

Benefits: bereavement

Whilst GPs are not supposed to be experts on claimable benefits, a rough understanding is expected

Funeral payment	One-off payment to the partner or parent of the deceased if they are on benefits to help pay for a funeral
Bereavement payment	Lump sum given to spouse if they are under the state pension age when their partner died Depends on national insurance contributions Not payable to divorcees
Bereavement allowance	Taxable weekly benefit paid to the spouse for up to 52 weeks from the date of death, if the surviving partner is 45 years or older and less than the state pension age
Widowed Parent's Allowance	Payable to a parent whose husband or wife has died. Eligibility • surviving partner is bringing up a child < 19 years of age and receiving child benefit • deceased partner had made adequate national insurance contributions • also if the woman was expecting her late husband's baby • divorcees and those who remarry and not eligible to claim

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

External links

DirectGov
Bereavement benefits

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Next question

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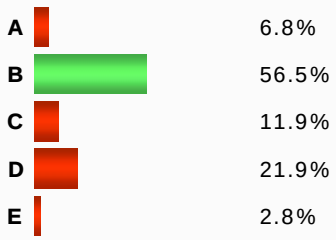
Question 5 of 165

Which coding system is being brought in by NHS Connecting For Health to replace Read codes?

- A. CDISC
- ✓ B. SNOMED CT
- C. MEDCIN
- D. NHSCS
- E. DOCLE

Next question

Question stats



56.5% of users answered this question correctly

Session score = 0%

Information management and technology

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

Information management and technology is one of the key parts of the RCGP curriculum

Clinical coding systems

- Read codes: used to code almost any aspect of medical care including symptoms, examinations, investigations, administration, diagnoses and treatment
- SNOMED CT (Systematized Nomenclature of Medicine -- Clinical Terms) is a new system which is replacing Read codes. It will be used by NHS Connecting For Health as the standard terminology for the NHS Care Records Service

Connecting for health

- the NHS Care Records Service (NHS CRS) will be connected by what is known as 'the spine'
- a key part of the NHS CRS will be the gradual development of an electronic Summary Care Record
- Choose and Book will allow GPs and other primary care staff to make initial hospital or clinic outpatient appointments using the spine
- provide a Secondary Uses Service (SUS), using anonymised data for business reports and statistics for research and planning purposes
- Electronic Prescription Service (EPS) is being planned meaning GPs will prescribe a drug electronically after which pharmacists will be able to dispense without a written prescription

Rate question:

Next question

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Question 6 of 165

A patient asks for a copy of her medical records. Which one of the following documents is most applicable to this request?

- A. Data Protection Act 1998
- B. Patient Records Act 2007
- C. NHS Constitution
- D. Freedom of Information Act 2000
- E. BMA 'Information for Patients' guidelines

Next question

The Freedom of Information Act 2000 does not normally deal with requests for personal data. The Patient Records Act 2007 is fictional.

Data Protection Act

The 1998 Data Protection Act is the main piece of legislation that governs the protection of personal data in the UK. The Act covers both manual and computerised records.

There are 8 main principles of the Data Protection Act:

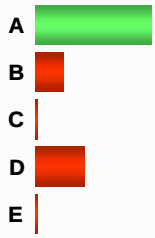
- data must be used for the specific purpose it was collected
- data must not be disclosed to other parties without the consent of the individual whom it is about
- individuals have a right of access to the information held about them
- personal information may be kept for no longer than is necessary and must be kept up-to-date
- personal information may not be transmitted outside the European Union unless consent has been given
- all entities (e.g. a GP surgery) that process personal information must register with the Information Commissioner's Office
- adequate security measures must be in place. Those include technical measures (e.g. passwords, firewalls) and organisational measures (e.g. staff training)
- subjects (i.e. patients) have the right to have factually incorrect information about them corrected

Rate question:

Next question

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Question stats



58.8% of users answered this question correctly

Session score = 0%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

External links

Information Commissioner's Office
Guidelines on recording opinions

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Question 7 of 165

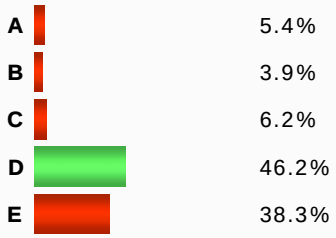
A 21-year-old female is seen in the first seizure clinic in the outpatient department. Both the EEG and MRI brain are normal. A decision is made not to start her on anti-epileptic medication. What restrictions on driving should she be informed about?

- A. No restrictions but inform DVLA
- B. No restrictions, no need to inform DVLA if not on medication
- C. Cannot drive for 1 month from date of seizure
- ✓ D. Cannot drive for 6 months from date of seizure
- E. Cannot drive for 1 year from date of seizure

Next question

Patients cannot drive for 6 months following a seizure

Question stats



46.2% of users answered this question correctly

Session score = 0%

RCGP curriculum

15.7 - Neurological Problems

Knowledge

Curriculum statement

External links

DVLA
Neurological disorder guidelines

DVLA: neurological disorders

The guidelines below relate to car/motorcycle use unless specifically stated. For obvious reasons, the rules relating to drivers of heavy goods vehicles tend to be much stricter

Specific rules

- first seizure: 6 months off driving*. For patients with established epilepsy they must be fit free for 12 months before being able to drive
- stroke or TIA: 1 month off driving
- multiple TIAs over short period of times: 3 months off driving
- craniotomy e.g. For meningioma: 1 year off driving**
- pituitary tumour: craniotomy: 6 months; trans-sphenoidal surgery 'can drive when there is no debarring residual impairment likely to affect safe driving'
- narcolepsy/cataplexy: cease driving on diagnosis, can restart once 'satisfactory control of symptoms'

Syncope

- simple faint: no restriction
- unexplained, low risk of recurrence: 4 weeks off
- explained and treated: 4 weeks off
- unexplained: 6 months off

*previously rule was 12 months. It is now 6 months off driving if the licence holder has undergone assessment by an appropriate specialist and no relevant abnormality has been identified on investigation, for example EEG and brain scan

where indicated

**if the tumour is a benign meningioma and there is no seizure history, licence can be reconsidered 6 months after surgery if remains seizure free

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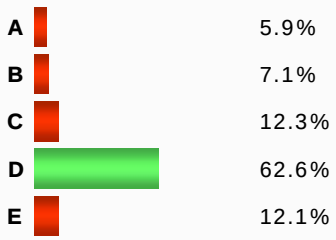
Question 8 of 165

A 24-year-old man who has been discharged following admission for a spontaneous pneumothorax ask for advice about flying. During his stay in hospital the pneumothorax was aspirated and a check x-ray revealed no residual air. What is the earliest time he should fly?

- A. Immediately
- B. 24 hours
- C. 3 days
- ✓ D. 2 weeks
- E. 2 months

Next question

Question stats



62.6% of users answered this question correctly

Session score = 0%

Please see the text below for an explanation about the competing and changing guidelines.

Fitness to fly

The Civil Aviation Authority (CAA) has issued guidelines on air travel for people with medical conditions; please see the link provided.

Cardiovascular disease

- unstable angina, uncontrolled hypertension, uncontrolled cardiac arrhythmia, decompensated heart failure, severe symptomatic valvular disease: should not fly
- uncomplicated myocardial infarction: may fly after 7-10 days
- complicated myocardial infarction: after 4-6 weeks
- coronary artery bypass graft: after 10-14 days
- percutaneous coronary intervention: after 5 days

Respiratory disease

- pneumonia: should be 'clinically improved with no residual infection'
- pneumothorax: absolute contraindication, the CAA suggest patients may travel 2 weeks after successful drainage if there is no residual air. The British Thoracic Society used to recommend not travelling by air for a period of 6 weeks but this has now been changed to 1 week post check x-ray

Pregnancy

- most airlines do not allow travel after 36 weeks for a single pregnancy and after 32 weeks for a multiple pregnancy
- most airlines require a certificate after 28 weeks confirming that the pregnancy is progressing normally

Surgery

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

External links

Civil Aviation Authority
Fitness to fly guidelines

- travel should be avoided for 10 days following abdominal surgery
- laparoscopic surgery: after 24 hours
- colonoscopy: after 24 hours
- following the application of a plaster cast, the majority of airlines restrict flying for 24 hours on flights of less than 2 hours or 48 hours for longer flights

Haematological disorders

- patients with a haemoglobin of greater than 8 g/dl may travel without problems (assuming there is no coexisting condition such as cardiovascular or respiratory disease)

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Next question

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Questions 9 to 11 of 165

Theme: Consultation models

A Heron
B Byrne and Long
C Berne
D Fraser
E Neighbour
F Calgary-Cambridge
G Stott and Davis
H Helman's folk model
I Pendleton

For each of the following tasks select the consultation model most associated with it

9. Building the relationship

Heron

The correct answer is Calgary-Cambridge

10. Relating to patients

Heron

The correct answer is Fraser

11. Housekeeping

Heron

The correct answer is Neighbour

Next question

Question stats

Average score for registered users:

9	39.9%
10	28%
11	80.8%

Session score = 0%

RCGP curriculum

2 - The General Practice Consultation

Curriculum statement

Consultation models

Calgary-Cambridge observation guide- Kurtz and Silverman - 1996

- initiating the session
- gathering information
- building the relationship

- giving information, explaining and planning
- closing the session

Stewart - patient-centred clinical method - 1995. 2003

- exploring both the disease and the illness experience
- understanding the whole person
- finding common ground
- incorporating prevention and health promotion
- enhancing the doctor-patient relationship
- being realistic (with time and resources)

Pendleton - The Consultation: an Approach to Learning and Teaching - 1984, 2003

- define the reason for the patient's attendance (ideas, concerns and expectations)
- consider other problems
- with the patient, choose an appropriate action for each problem
- achieve a shared understanding of the problems with the patient
- involve the patient in the management and encourage him/her to accept appropriate responsibility
- use time and resources appropriately
- establish or maintain a relationship with the patient which helps to achieve the other tasks

Fraser - Areas of competence - 1992

- interviewing and history-taking
- physical examination
- diagnosis and problem-solving
- patient management
- relating to patients
- anticipatory care
- record keeping

Neighbour - The Inner Consultation - five checkpoint model - 1987

- connecting
- summarising
- handing over
- safety netting
- housekeeping

Tuckett - meeting of two experts - 1985

- the consultation is a meeting between two experts
- doctors are experts in medicine
- patients are experts in their own illnesses
- shared understanding is the aim
- doctors should seek to understand the patient's beliefs
- doctors should address explanations in terms of the patient's belief system

Stott and Davis - Exceptional potential of the consultation - 1979

- management of presenting problems
- management of continuing problems
- modification of help-seeking behaviour
- opportunistic health promotion

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Question 12 of 165

Following the introduction of revalidation, how often will doctors have to submit evidence to assess their fitness to practise?

- A. Every 2 years
- B. Every 12 months
- C. Every 3 years
- ✓ D. Every 5 years
- E. Every 10 years

Next question

Question stats

A	3.1%
B	8.4%
C	7.3%
D	80.9%
E	0.3%

80.9% of users answered this question correctly

Session score = 0%

Revalidation

Revalidation introduces a change in the way doctors are licensed and certificated. Currently UK doctors automatically receive their licence to practise if they have paid their annual fee and have no limitations on their registration (e.g. Following a GMC ruling). To practise as a GP doctors must also be on the GP Register - a process known as certification.

Following the introduction of revalidation doctors will be required to prove their fitness to practise to allow them to continue to work as a doctor. Revalidation will occur every 5 years and in one process combine relicensing and recertification. Annual appraisals will continue as before but there will be a focus on whether the doctor is making sufficient progress towards their revalidation portfolio.

The type and amount of evidence required will be similar to that needed for appraisals currently. The RCGP is creating an ePortfolio for the process and proposes that it should contain the following (please see the link for more details):

- description of your work
- description of any special circumstances (e.g. Prolonged illness)
- details of previous appraisals
- current personal development plan
- review of previous personal development plans
- evidence of continuing professional development - at least 50 'learning credits' are required per year
- multi-source feedback
- patient questionnaire surveys
- significant event audits
- review of any formal complaints
- probity/health statements

Learning credits

- minimum of 1 credit for each hour of education
- however, if the hour of education can be shown to lead to improvements in

RCGP curriculum

3.1 - Clinical Governance

Curriculum statement

External links

RCGP
Revalidation

patient care then it will count as 2 credits

Submitting the evidence for revalidation

- the ePortfolio will be submitted electronically for review
- the review will be done by a 'Responsible Officer'
- the Responsible Officer is likely to be advised by a GP assessor and a trained lay person
- if the submitted evidence is considered sufficient the Responsible Officer will recommend to the GMC that the doctor is both relicensed and recertificated

Revalidation is due to be phased in from 2011 to 2016.

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Question 13 of 165

One of your colleagues confides in you that he has just been diagnosed with hepatitis B. He has not told anyone else as he is worried he may lose his job. He is currently working as a general surgeon in the local hospital. You try to persuade him to inform occupational health but he refuses. What is the most appropriate action?

- A. Keep confidentiality but ask him to stop taking blood
- B. Send an anonymous letter to his employer
- C. Keep confidentiality
- ✓ D. Inform your colleague's employing body
- E. Contact the police

Next question

Whilst this may seem harsh patient safety has to be paramount. Please see the updated GMC guidelines for further details.

GMC guidance: confidentiality

We will not try to replicate the extensive guidance given by the General Medical Council here. There is a link available for more detailed information.

Rate question:

Next question

Comment on this question

Question stats

A	20.9%
B	0.7%
C	4.1%
D	74%
E	0.4%

74% of users answered this question correctly

Session score = 0%

RCGP curriculum

3.3 - Ethics and Values Based Medicine

Curriculum statement

External links

GMC
Confidentiality guidance

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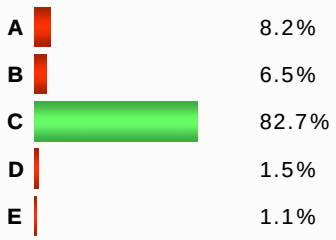
Question 14 of 165

Which one of the following places is it not suitable to store a controlled drug?

- A. In a doctor's bag with a combination lock
- B. In a doctor's bag with a key lock
- ✓ C. In a locked car boot
- D. In the surgery inside a locked cabinet
- E. In the surgery inside a locked safe

Next question

Question stats



82.7% of users answered this question correctly

Session score = 0%

Controlled drugs: storage and register

Storage

In the surgery controlled drugs (CDs) should be stored in a locked cabinet.

Controlled drugs outside of the surgery must be stored in a locked receptacle (combination lock or key). A doctor's bag with a lock is acceptable. It should be noted that storing a controlled drug in a locked car boot is not acceptable.

Register

A register must be kept for the supply of Schedule 2 drugs.

Specific requirements of the register:

- must be bound rather than loose leaved. Computerised records are acceptable as long as they are secure and auditable
- each drug should have its own individual section
- entries should be chronological and made in indelible ink
- the following information should be recorded when receiving CDs: date, name and address of the supplier, quantity received, name, form and strength
- the following information should be recorded when supplying CDs (either to patients or practitioners): date, name and address of the person receiving the CD, person who prescribed or ordered the CD, quantity supplied, name, form and strength
- must be kept for a minimum of 2 years after the date of the last entry

For doctor's bags a separate CD register should be kept for the CD stock held within that bag. The individual doctor is responsible for the receipt and supply of CDs from their own bag.

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

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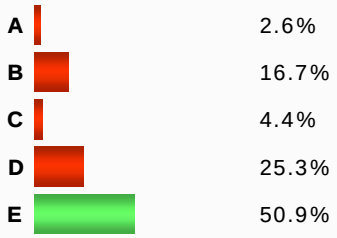
Question 15 of 165

Which one of the following patients is not entitled to free prescriptions in England?

- A. Unemployed 26-year-old man receiving the jobseeker's allowance with lower back pain
- B. 62-year-old man who is fit and well
- C. 18-year-old full-time college student with acne
- D. 36-year-old whose partner is claiming income support
- ✓ E. 58-year-old woman with Crohn's disease

Next question

Question stats



50.9% of users answered this question correctly

Session score = 0%

Prescription charges

The following information applies to England. Wales has abolished prescription charges and Scotland plans to remove prescription charges altogether by 2011.

Who is entitled to free prescriptions?

- children (< 16 years old)
- aged 16, 17 or 18 and in full-time education
- elderly (aged 60 or over)
- if the patient or their partner receives: income support or jobseeker's allowance
- if the patient has a prescription exemption certificate

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

Prescription exemption certificate

Women who are pregnant or have had a child in the past year are entitled to free prescriptions after the issuing of a prescription exemption certificate. Patients who have the following chronic medical conditions are also entitled:

- hypoparathyroidism
- hypoadrenalism for which specific substitution therapy is essential (e.g. Addison's Disease)
- diabetes insipidus and other forms of hypopituitarism
- diabetes mellitus except where treatment is by diet alone
- myasthenia gravis
- hypothyroidism requiring thyroid hormone replacement
- epilepsy requiring continuous anti-convulsive therapy
- a permanent fistula requiring continuous surgical dressing or requiring an appliance
- undergoing treatment for cancer. This includes treatment for the effects of cancer or for the effects of cancer treatments

Pre-payment certificate

Pre-payment certificates (PPC) are for patients not entitled to free prescriptions but who receive frequent prescriptions. They are cheaper if the patient pays for more than 14 prescriptions per year

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Next question

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Question 16 of 165

On the Statement of Fitness for Work form which one of the following is not included as one of the tick box options?

- A. Altered hours
- B. Work place adaptations
- C. A phased return to work
- D. Amended duties
- ✓ E. Light duties

Next question

Question stats

A	8.7%
B	7.1%
C	2.9%
D	3.5%
E	77.7%

77.7% of users answered this question correctly

Session score = 0%

Statement of Fitness for Work

In 2010 sick notes became fit notes, or more formally the Statement of Fitness for Work. They have been introduced to reflect the fact that in the majority of cases patients do not need to be 100% fit before returning to work. The major change is allowing a doctor to advise that a patient 'may be fit for work taking account of the following advice'.

This information is taken from the Department of Work and Pensions website. Please see the link for further details.

Other changes

- the Statement of Fitness for Work replaces the Med3 and Med5 in one form
- the Med4, Med6 and RM 7 forms have been withdrawn due to the replacement of Incapacity Benefit with the Employment and Support Allowance
- telephone consultations are now an acceptable form of assessment
- there is no longer a box to say a patient is fit for work. There is however an option to state if you need to assess your patient's fitness for work again at the end of the statement period
- there is increased space for comments on the functional effects of the condition, including tick boxes for simple things that may help a patient back to work
- during the first 6 months of an illness the new statement can be issued for no longer than 3 months.. After this time it may be issued for an indefinite period

Things that stay the same

- can only be completed by a doctor
- you can still the advise a patient that they are not fit for work (of any type)
- the advice on the statement is not binding on employers

The statement may be issued:

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

External links

Department of Work and Pensions
Statement of Fitness for Work

- on the day that you assessed the patient
- on a date after you assessed your patient if you consider that it would have been reasonable to issue a statement on the day of the assessment
- after consideration of a written report from another doctor or registered health care professional

There are 4 'tick boxes' included on the form which represent common approaches to aid a return to work. One or more may be ticked. Other approaches can be suggested in the comments box. The options are:

- a phased return to work
- altered hours
- amended duties
- workplace adaptations

Patients may self-certify for the first 7 calendar days:

SC1	Self-certification, for patients not eligible to claim statutory sick pay (e.g. Unemployed or self-employed). For the first 7 calendar days of an illness
SC2	The 'standard' self-certification form, for patients eligible to claim statutory sick pay. For the first 7 calendar days of an illness

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Question 17 of 165

Which one of the following entries on a death certificate would never be acceptable?

- A. 1a: Tuberculous meningitis. 1b: HIV infection
- ✓ B. 1a: Cardiac arrest. 2: Non-insulin dependent diabetes mellitus
- C. 1a: Intraventricular haemorrhage. 1b: Warfarin anticoagulation. 1c: Atrial fibrillation
- D. 1a: Old age. 2: Non-insulin dependent diabetes mellitus (93-year-old patient)
- E. 1a: Liver failure. 1b: Alcoholic liver disease

Next question

Cardiac arrest is a mode of dying and cannot be used unqualified on a death certificate

'Old age' is discouraged but can be used in patients greater than the age of 80 years with no qualification if certain conditions are met (please see link)

HIV and AIDS are the only acceptable abbreviations

Death certification

There is no legal definition of death in the UK although guidelines exist. Current guidance states 'death should be verified by a doctor, or other suitably qualified personnel' which means staff such as nurse practitioners may verify (but not certify) death.

After a patient has died a doctor needs to complete a medical certificate of cause of death (MCCD). There is a list of circumstances in which a doctor should notify the Coroner prior to completing the MCCD.

Some specific points on completing the MCCD:

- 'old age' as 1a is only acceptable if the patient was at least 80 years of age . It can be used if certain conditions are met but is discouraged
- 'natural causes' is not acceptable
- organ failure (e.g. 'liver failure') can only be used if you specify the disease or

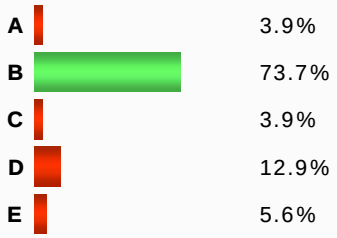
condition that led to the organ failure (e.g. 1b: Hepatitis C)

- abbreviations should be avoided (except HIV and AIDS*)

The family then take the MCCD to the local Registrar of Births, Deaths, and Marriages office to register the death. If the Registrar decides that the death does not need reporting to the Coroner he/she will issue:

- certificate for Burial or Cremation
- certificate of Registration of Death (for Social Security purposes)

Question stats



73.7% of users answered this question correctly

Session score = 0%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

External links

Home Office
Guidance for doctors completing Medical Certificates

Ministry of Justice
Cremation guidelines

- if requested. Copies of the Death Register (banks and insurance companies expect to see them)

If the family would like the burial to be outside of England, an Out of England Order is needed from the coroner.

*why this is I'm not sure - probably due to how well known the terms are amongst the general public

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Next question

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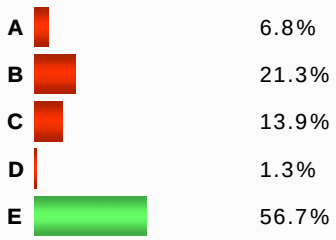
Question 18 of 165

A 54-year-old man consults you about erectile dysfunction. Which one of the following conditions would allow a prescription of a phosphodiesterase type-5 inhibitor to be made on the NHS?

- A. Hypothyroidism
- B. Testicular cancer treated with chemotherapy
- C. Peripheral arterial disease with previous amputation
- D. Non-alcoholic liver cirrhosis
- ✓ E. Renal failure treated with dialysis

Next question

Question stats



56.7% of users answered this question correctly

Session score = 0%

Part XVIIIA of the Drug Tariff - The Blacklist

Theoretically any food, drug, toiletry or cosmetic may be prescribed on an NHS prescription unless the product is listed in Part XVIIIA of the Drug Tariff ('the blacklist').

Medical devices (appliances) can only be prescribed on NHS prescriptions if the product is listed in Part IX of the Drug Tariff.

If a proprietary product is listed in 'the blacklist', it cannot be dispensed on the NHS. The only exception to this is if the prescription is issued using a generic name and the generic name is not itself included in the blacklist.

Some examples of 'blacklisted' products:

- Propecia (finasteride for male-pattern alopecia)
- Regaine (topical minoxidil for male-pattern alopecia)
- Calpol (see above, paracetamol suspension may be prescribed)

The Selected List

Part XVIIIB of the Drug Tariff lists items that may only be prescribed for the patient groups and for the purpose listed in the Drug Tariff. Prescribers must endorse prescriptions for these products 'SLS'. This section covers the prescription of phosphodiesterase type-5 inhibitors.

For example:

- Niferex Elixir 30ml Paediatric Dropper Bottle - infants born prematurely - prophylaxis in treatment of iron deficiency
- sildenafil - only if treated prior to September 1998 or if has one of the following conditions: diabetes mellitus, Parkinson's disease, poliomyelitis, multiple, sclerosis, prostate cancer, severe pelvic injury, single gene neurological disease, spina bifida, spinal cord injury, renal failure treated with dialysis or transplant, prostatectomy or radical pelvic surgery

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

External links

NHS
Electronic Drug Tariff

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Question 19 of 165

During a busy morning clinic the receptionists phone you. They have triaged an urgent visit request for a man with metastatic prostate cancer who is in severe pain. You are running 20 minutes behind already and are not due to finish clinic for another two hours. What is the most appropriate action?

- A. Delegate the task to the practice nurse
- ✓ B. Inform the other doctors and go and see the patient immediately
- C. Advise the patient about relaxation techniques
- D. Finish your surgery then go and see the patient
- E. Advise the patient to phone for an ambulance

Next question

This scenario looks at how urgently a patient with severe pain should be seen. In most similar scenarios, for example a patient who phones due to chest pain, the most appropriate response is phone for an ambulance. However, in the palliative setting this may not be appropriate.

The best response is therefore to go immediately and see the patient at home. Whilst this will inevitably have knock-on effects to your surgery the alternative is to leave the patient is pain.

Advising the patient to phone for an ambulance will at least get the patient seen but may not be appropriate in such an scenario.

Relaxation techniques are unlikely to be effective in the context of breakthrough pain. This is not a job for the practice nurse.

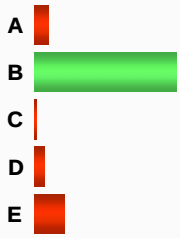
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Question stats



71.9% of users answered this question correctly

Session score = 0%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

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Questions 20 to 22 of 165

Theme: Scoring systems used in medicine

A Gleason score
B Bishop score
C Smith scale
D CHADS2
E ABCD2
F DAS28
G MMSE
H BRIC
I CURB-65
J Epworth scale

For each of the following please select the appropriate scoring system:

20. Used in the assessment of suspected obstructive sleep apnoea

Gleason score

The correct answer is Epworth scale

21. Used to determine the need to anticoagulate a patient in atrial fibrillation

Gleason score

The correct answer is CHADS2

22. Measure of disease activity in rheumatoid arthritis

Gleason score

The correct answer is DAS28

Next question

Question stats

Average score for registered users:

20	73.6%
21	78.7%
22	50.9%

Session score = 0%

Scoring systems

There are now numerous scoring systems used in medicine. The table below lists some of the more common ones:

CHADS2	Used to determine the need to anticoagulate a patient in atrial fibrillation
ABCD2	Prognostic score for risk stratifying patients who've had a suspected TIA
NYHA	Heart failure severity scale
DAS28	Measure of disease activity in rheumatoid arthritis
Child-Pugh classification	A scoring system used to assess the severity of liver cirrhosis
Wells score	Helps estimate the risk of a patient having a deep vein thrombosis
MMSE	Mini-mental state examination - used to assess cognitive impairment
HAD	Hospital Anxiety and Depression (HAD) scale - assesses severity of anxiety and depression symptoms
PHQ-9	Patient Health Questionnaire - assesses severity of depression symptoms
GAD-7	Used as a screening tool and severity measure for generalised anxiety disorder
Edinburgh Postnatal Depression Score	Used to screen for postnatal depression
SCOFF	Questionnaire used to detect eating disorders and aid treatment
AUDIT	Alcohol screening tool
CAGE	Alcohol screening tool
FAST	Alcohol screening tool
CURB-65	Used to assess the prognosis of a patient with pneumonia
Epworth Sleepiness Scale	Used in the assessment of suspected obstructive sleep apnoea
IPSS	International prostate symptom score
Gleason score	Indicates prognosis in prostate cancer
APGAR	Assesses the health of a newborn immediately after birth
Bishop score	Used to help assess the whether induction of labour will be required
Waterlow score	Assesses the risk of a patient developing a pressure sore
FRAX	Risk assessment tool developed by WHO which calculates a patients 10-year risk of developing an osteoporosis related fracture

Can you think of any other commonly used scoring systems?

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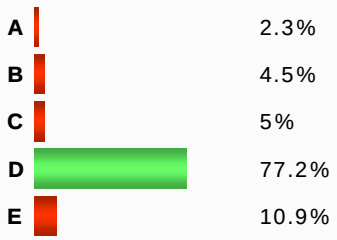
Question 23 of 165

Which one of the following is not a key principle of the 2005 Mental Capacity Act?

- A. An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests
- B. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success
- C. A person must be assumed to have capacity unless it is established that he lacks capacity
- ✓ D. A person's ability to make decisions must be reviewed on an annual basis
- E. A person is not to be treated as unable to make a decision merely because he makes an unwise decision

Next question

Question stats



77.2% of users answered this question correctly

Session score = 0%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

Mental Capacity Act

The Mental Capacity Act of 2005 came into force in 2007. It applies to adults over the age of 16 and sets out who can take decisions if a patient becomes incapacitated (e.g. following a stroke). Mental capacity includes the ability to make decisions affecting daily life, healthcare and financial issues.

The Act contains 5 key principles:

- A person must be assumed to have capacity unless it is established that he lacks capacity
- A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success
- A person is not to be treated as unable to make a decision merely because he makes an unwise decision
- An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests
- Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action

Assessment of capacity

The Act sets out a clear test for assessing whether a person lacks capacity. It is a 'decision-specific' and 'time-specific' test. An adult can only be considered unable to make a particular decision if:

1. He or she has an 'impairment of, or disturbance in, the functioning of the mind or
brain' whether permanent or temporary AND

2. He or she is unable to undertake any of the following

- a. understand the information relevant to the decision
- b. retain that information
- c. use or weigh that information as part of the process of making the decision
- d. communicate the decision made by talking, sign language or other means

No individual can be labelled 'incapable' simply as a result of a particular medical condition. Section 2 of the Act makes it clear that a lack of capacity cannot be assumed by a person's age, appearance, or any condition or aspect of a person's behaviour

Best interests

The following should be considered when assessing what is in someone's best interests:

- 1. Whether the person is likely to regain capacity and can the decision wait.
- 2. How to encourage and optimise the participation of the person in the decision.
- 3. The past and present wishes, feelings, beliefs, values of the person and any other relevant factors
- 4. Views of other relevant people

Lasting Powers of Attorney (LPAs)

The Act allows a person to appoint an attorney to act on their behalf if they should lose capacity in the future, replacing the current Enduring Power of Attorney (EPA). In addition to property and financial affairs the Act also allows people to empower an attorney make health and welfare decisions. The attorney only has the authority to make decisions about life-sustaining treatment if the LPA specifies that. Before it can be used an LPA must be registered with the Office of the Public Guardian

Advance decisions

Advance decisions can be drawn up by anybody with capacity to specify treatments they would not want if they lost capacity. They may be made verbally unless they specify refusing life-sustaining treatment (e.g. Ventilation) in which case they need to be written, signed and witnessed to be valid. Advance decisions cannot demand treatment

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Question 24 of 165

Which one of the following is not a part of the Carr-Hill allocation formula when deciding upon the global sum a Practice based in England receives?

- A. Standardised Mortality Ratio for patients < 65 years
- B. Rurality
- ✓ C. Socioeconomic group
- D. List turnover
- E. Nursing and residential home patients

Next question

In England the socioeconomic status of the patients is not part of the Carr-Hill formula. The additional needs calculation in Scotland is however partly based on unemployment rates and levels of deprivation

GP contract: Carr-Hill formula

The Carr-Hill allocation formula is used to adjust the global sum total for a number of local demographic and other factors which may affect Practice workload. For example, a Practice with a large number of elderly patients may have a higher workload than one which primarily cares for commuters. The Carr-Hill formula replaced the Jarman index

Factors included in the Carr-Hill formula

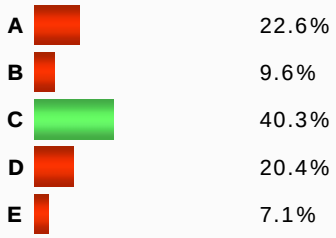
- age and sex of patients
- nursing and residential home patients
- list turnover: adjusted for number of new registrations
- additional needs: Standardised Mortality Ratio and Standardised Long-Standing Illness for patients under the age of 65 years
- staff market forces factor
- rurality
- London weighting

Rate question:

Next question

Comment on this question

Question stats



40.3% of users answered this question correctly

Session score = 0%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

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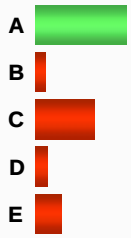
Question 25 of 165

The local deanery want to write a curriculum for the out-of-hours training of GP registrars. They send an initial a questionnaire to a number of local GPs and ask them what things they think should be included. Based on the results of this initial questionnaire a second questionnaire which distills the information and asks more specific questions is sent. What is this an example of?

- A. A Delphi process
- B. The Berne method
- C. Qualitative feedback method
- D. A Calgary-Cambridge process
- E. The iterative response model

Next question

Question stats



45.8% of users answered this question correctly

Session score = 0%

Delphi process

A Delphi process (also known as the Delphi method or technique) is a structured way of collecting and distilling the knowledge from a group of experts, often about issues where there is little formal evidence.

It consists of a number of 'rounds' of questionnaires. The first round tends to ask the experts a number of broad questions. The results of the first round are then sorted and common themes are distilled down. This information then goes on to form the second, more specific, questionnaire which again is sent out to the panel of experts. This iterative process is usually repeat two or three times.

Examples of where the Delphi method may be used:

- curriculum development: i.e. Involving a range of expert stakeholders in finding out what they feel should be included
- guideline development: the expert panel may include doctors, nurses, pharmacists and patients
- forecasting future health problems

One of the key features of a Delphi process is the anonymity of the participants. This prevents individual participants from dominating the opinion forming process.

Please see the link for an excellent review by Dr Thangaramtinum and Mr Redman.

RCGP curriculum

3.6 - Research and Academic Activity

Curriculum statement

External links

RCOG
The Delphi technique

Rate question:

Next question

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Question 26 of 165

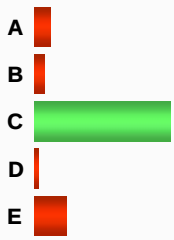
Which one of the following best describes the role of Caldicott guardians?

- A. Designated senior doctor who takes responsibility for elderly patients who lack capacity
- B. Monitor adherence to employment legislation in the Practice
- ✓ C. Protect access to confidential patient data
- D. Protect access to controlled drugs in the Practice
- E. Designated senior doctor who takes responsibility for child protection

Next question

Caldicott guardian - protect patient data

Question stats



69.2% of users answered this question correctly

Session score = 0%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

Caldicott guardian

The 1997 Caldicott Report identified weaknesses in the way parts of NHS handled confidential patient data. The report recommended the appointment of Caldicott Guardians, a member of staff with responsibility to ensure patient data is kept secure

It is now a requirement for every NHS organisation to have a Caldicott Guardian

Rate question:

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Question 27 of 165

You are a GP registrar on a weekend away with a close friend and his wife. Their young child has been unwell since the morning and has now become pyrexial with an evolving purpuric rash. You have a drugs bag in the back of your car. What is the most appropriate action?

- A. Phone 999 + then contact your medical indemnity provider for advice
- B. Walk away from the situation to avoid a potential conflict of interest
- C. Phone 999 + don't give benzylpenicillin
- D. Phone 999 + ask a passerby who doesn't know the child to draw-up and give benzylpenicillin
- ✓ E. Phone 999 + give benzylpenicillin to your friend's child

Next question

It is normally advised that doctors should not treat themselves or close family/friends. However, this question tests whether a doctor has the professional judgement to act appropriately in an emergency situation.

Given that the child may have meningococcal septicaemia it is vital that an ambulance is called for immediately. The decision is then what to do next. As this is an emergency situation you should give treatment. Phoning your medical indemnity provider for advice will take time but it is probable you will given advice that it is ok to give the benzylpenicillin prior to the ambulance arriving. Withholding the antibiotic is inappropriate in a child with potential meningococcal septicaemia. Giving the antibiotic to a passerby risks is inappropriate as it risks the wrong dose being given.

_

Rate question:

Next question

Comment on this question

Question stats

A	2.8%
B	0.2%
C	2.7%
D	0.3%
E	94.1%

94.1% of users answered this question correctly

Session score = 0%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

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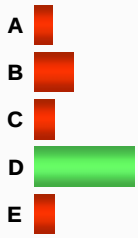
Question 28 of 165

Which one of the following statements regarding Local Medical Committees (LMC) is true?

- A. LMCs are funded by the Department of Health
- B. LMC members are appointed by the Primary Care Trust
- C. There is one LMC per Primary Care Trust
- ✓ D. LMC members include GP Registrars
- E. LMC policy is determined by the General Practitioners Committee

Next question

Question stats



51.3% of users answered this question correctly

Session score = 0%

Local Medical Committees

Local Medical Committees (LMCs) represent the interests of GPs on a local level. They were established as part of Lloyd George's National Insurance Act in 1911 to try and ensure that GPs had a say in the running of the government's health insurance scheme. At the same time a committee was established within the British Medical Association (BMA) to represent GPs on a national level to the government. This was initially known as the Insurance Acts Committee but is now called the General Practitioners Committee (GPC) and has authority to negotiate with the government on matters such as pay and contracts. It is recognised by the Department of Health as the GP's sole negotiating body.

The GPC meets annually with the representatives of the LMCs, who may submit motions for the conference. This motions may then go on to form GPC policy.

LMCs are funded by a statutory levy on GPs. Each LMC may cover the area which corresponds to one or more Primary Care Trusts. LMC members are elected and include partners, salaried doctors and GP Registrars from both GMS and PMS practices .

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

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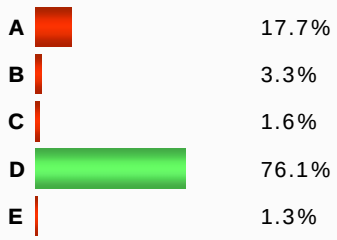
Question 29 of 165

You write a prescription for MST for a patient with metastatic breast cancer. Later in the day you receive a phone call from the local pharmacist. He has noticed that whilst you stated the total quantity to dispense in figures you failed to write it in words. Of the following options, which one is most appropriate?

- A. The pharmacist may issue one days supply at the stated dose
- B. You should complete a 'Yellow card'
- C. The prescription should be destroyed and the patient asked to make an appointment with a different doctor
- ✓ D. The pharmacist may amend the prescription and add the total quantity in words
- E. You must wait 24 hours before issuing a further prescription

Next question

Question stats



76.1% of users answered this question correctly

Session score = 0%

A pharmacist is generally not allowed to dispense unless all the information required by law is given. With Schedule 2 and 3 drugs a pharmacist is allowed to amend the prescription if 'it specifies the total quantity only in words or in figures or if it contains minor typographical errors, provided that such amendments are indelible and clearly attributable to the pharmacist making them'

RCGP curriculum

3.2 - Patient Safety

Curriculum statement

Controlled drugs

When prescribing a controlled drug the following must be present on the prescription:

- name and address of the patient
- the form, and where appropriate the strength, of the preparation

- either the total quantity (in both words and figures) of the preparation, or the number (in both words and figures) of dosage units to be supplied

- the dose (cannot write 'as directed')
- prescribers name, signature, address and current date

The 2001 Misuse of Drugs Regulations act defines who is authorised to prescribe controlled drugs. It divided drugs of potential abuse into 5 categories ('schedules') each with own rules on prescribing, supply, possession, record keeping etc

Schedule 1	Cannabis, lysergide
Schedule 2	Diamorphine, morphine, pethidine, amphetamine, cocaine
Schedule 3	Barbiturates, buprenorphine, midazolam*, temazepam**
Schedule 4	**Part 1**: Benzodiazepines (except midazolam and temazepam) and zolpidem

External links

UK Government
Misuse of Drugs Regulations 2001

	Part 2: Androgenic and anabolic steroids, hCG, somatropin Controlled drug prescription requirements do not apply and Schedule 4 controlled drugs are not subject to safe custody requirements
Schedule 5	Includes preparations which because of their strength are exempt from the vast majority of Controlled Drug requirements other than retention of invoices (e.g. Oramorph 10mg/5ml)

Further selected points

- Schedule 2 and 3 drugs are marked 'CD' in the BNF
- a prescription for controlled drugs in Schedules 2,3 & 4 is valid for 28 days
- a pharmacist is generally not allowed to dispense unless all the information required by law is given. With Schedule 2 and 3 drugs a pharmacist is allowed to amend the prescription if 'it specifies the total quantity only in words or in figures or if it contains minor typographical errors, provided that such amendments are indelible and clearly attributable to the pharmacist making them'

*midazolam was changed from schedule 4 to 3 in 2008

**temazepam is excluded from the prescription requirements

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Next question

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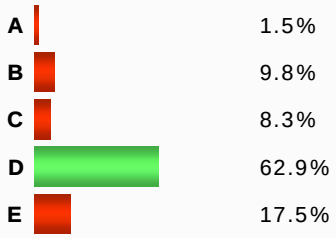
Question 30 of 165

Your surgery is selected to undergo a random visit by the Primary Care Trust (PCT) to ensure no irregularities in the Quality and Outcomes Framework reporting. Who will be on the routine PCT visiting team?

- A. GP + NHS counter-fraud auditor
- B. PCT management representative + NHS counter-fraud auditor + patient representative
- C. PCT management representative + NHS counter-fraud auditor
- ✓ D. PCT management representative + GP + patient representative
- E. PCT management representative + NHS counter-fraud auditor + GP

Next question

Question stats



62.9% of users answered this question correctly

Session score = 0%

Quality and Outcomes Framework

The Quality and Outcomes Framework (QOF) is the annual reward and incentive programme detailing GP practice achievement results. It was introduced as part of the new General Medical Services (GMS) to incentivise not only the management of chronic disease such as diabetes but also to improve the organisation of the practice and patient experience

Other points

- for clinical indicators the value of a point is determined by the prevalence of that condition in the practice
- participation in the QOF is voluntary
- 5% of practices should be visited at random to help prevent fraud. The PCT visiting team will normally consist of a PCT management representative, a GP and a patient representative

The table below shows the four key areas on which the QOF is based

Clinical indicators	697 points	Standards linked to the care of patients suffering from chronic diseases
Organisational	167.5 points	Standards relating to records and information, communicating with patients, education and training, medicines management and clinical and practice management
Additional services	44 points	Covering cervical screening, child health surveillance, maternity services and contraceptive services
Patient experience	91.5 points	Based on patient surveys and length of consultations

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

Patients may be 'exception reported' in the following situations:

- patients who have been recorded as refusing to attend review who have been invited on at least three occasions during the preceding 12 months
- patients for whom it is not appropriate to review the chronic disease parameters due to particular circumstances e.g. Terminal illness, extreme frailty
- patients newly diagnosed within the practice or who have recently registered with the practice, who should have measurements made within 3 months and delivery of clinical standards within 9 months e.g. Blood pressure or cholesterol measurements within target levels
- patients who are on maximum tolerated doses of medication whose treatment remain sub-optimal
- patients for whom prescribing a medication is not clinically appropriate e.g. Those who have an allergy, another contraindication or have experienced an adverse reaction
- where a patient has not tolerated medication
- where a patient does not agree to investigation or treatment (informed dissent), and this has been recorded in their medical records
- where the patient has a supervening condition which makes treatment of their condition inappropriate e.g. Cholesterol reduction where the patient has liver disease
- where an investigative service or secondary care service is unavailable

Rate question:

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Questions 31 to 33 of 165

Theme: Benefits

A Bereavement Allowance
B Bereavement Payment
C Statutory Sick Pay
D Disability Living Allowance
E Employment and Support Allowance
F State pension
G Income Support
H Job Seekers Allowance
I No benefits claimable

For each of the following scenarios select the claimable benefit

31. 62-year-old woman who works as a cleaner

Bereavement Allowance

The correct answer is State pension

The state pension is claimable even if the person is still working.

32. 45-year-old bank clerk who has not been working for the past 3 months due to depression

Bereavement Allowance

The correct answer is Statutory Sick Pay

33. A 20-year-old single mother who works 12 hours a week as a waitress

Bereavement Allowance

The correct answer is Income Support

As she is working less than 16 hours per week and on a low income she is entitled to income support

Next question

Question stats

Average score for registered users:

31	65.1%
32	71.5%
33	80.1%

Session score = 0%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

Benefits

Whilst GPs are not supposed to be experts on claimable benefits, a rough understanding is expected

Income support	Aged 16-59 years, on low income, working less than 16 hours per week and not receiving Job Seekers Allowance
Job Seekers Allowance	From 19 years old to state pension age. Claimants must be capable of working and agree to actively seek work
Disability Living Allowance	Tax-free benefit for children and adults who need help with personal care or have walking difficulties because they are physically or mentally disabled
Statutory Sick Pay	For employees unable to work due to illness. Unable to work for > 4 days in a row. Paid up to a maximum of 28 weeks
Incapacity Benefit & Employment and Support Allowance	Employment and Support Allowance replaced Incapacity Benefit for new claimants from October 2008. Claimable by those not entitled to Statutory Sick Pay (SSP), for example self-employed, or when SSP has ended
Retirement pension	State pension may be claimed from 60 years for women and 65 years for men. State pensions are taxable and paid even if the claimant is still working
Bereavement payment	Lump sum given to spouse if they are under state pension age when their partner died Depends on national insurance contributions Not payable to divorcees
Bereavement allowance	Taxable weekly benefit paid to the spouse for up to 52 weeks from the date of death, if the surviving partner is 45 years or older and less than the state pension age
Health in Pregnancy Grant	Payable to pregnant women between the 25th week of pregnancy and expected date of delivery. One-off lump sum, patients need form signing by midwife or doctor. Due to be scrapped from the 1st January 2011.

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Question 34 of 165

Which one of the following is not part of Helman's 'Folk model of illness'?

- ✓ A. What will the doctor do?
- B. Why has it happened?
- C. What would happen if nothing were done about it?
- D. What has happened?
- E. Why to me?

Next question

Question stats

A	58.6%
B	3.5%
C	12.8%
D	10.2%
E	14.9%

58.6% of users answered this question correctly

Session score = 0%

Helman's 'Folk model of illness'

Helman suggests that a patient with a problem comes to a doctor seeking answers to 6 questions:

- what has happened?
- why has it happened?
- why to me?
- why now?
- what would happen if nothing were done about it?
- what should I do about it?

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

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Question 35 of 165

Which one of the following reports provides details on the prescribing habits of practices?

- A. PPAMR
- B. GPPR
- ✓ C. PACT
- D. PCER
- E. GP-PPA-R

Next question

Question stats

A	16.5%
B	19.2%
C	50%
D	7.7%
E	6.6%

50% of users answered this question correctly

Session score = 0%

PACT

PACT stands for **P**rescribing **A**nalysis and **C**ost **T**abulation or **P**rescribing **A**nalysis and **C**os**T** . It is a document issued to each GP practice giving a summary of prescribing patterns.

- generic versus brand prescribing
- number of items dispensed (categorised as per BNF)
- information is available at individual practice level, health authority level, and national level, allowing different analyses

It is generated by the Prescription Pricing Authority (PPA)

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

Rate question:

Next question

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Question 36 of 165

A 44-year-old woman present to the GP surgery for a blood pressure check. You notice she has multiple bruises on her arms. She tells you there have been 'some problems at home' but doesn't want the police involved. What is the most appropriate action?

- A. Give her the details of a domestic violence support group
- B. Tell her that you have no alternative but to contact the police
- C. Check her FBC and clotting
- D. Draw a detailed diagram of her injuries + refer her for counselling
- E. Phone the partner after the patient as left and warn him of further action if he doesn't stop

Next question

Question stats

A	83.6%
B	2.4%
C	3.4%
D	10.4%
E	0.1%

83.6% of users answered this question correctly

Session score = 0%

Scenarios involving domestic violence can be difficult to deal with.

The people who are most likely to be able to offer practical advice are domestic violence support groups. They will have specific knowledge of housing and financial issues. A general counselling service is less able to provide this support and may imply to the women that you feel she is at fault. As she is reluctant for police involvement at this stage drawing a diagram of her injuries is less relevant although it is still good practice.

Checking her bloods is unlikely to be relevant – her bruises are likely to be a result of violence by her partner.

Unless you feared for the patient's life this is not a situation where you would break confidentiality. It is possible such action may put the woman at more risk of violence.

Phoning the partner directly is the worst option as this both breaks confidentiality and is likely to put the patient at risk of retribution.

–

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

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Next question

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Question 37 of 165

A 69-year-old man presents to surgery. He states he is unhappy that Dr Jones, one of your colleagues at the surgery, took so long diagnosing his wife with Parkinson's disease. What is the most appropriate response?

- A. Advise him to speak to Dr Jones directly
- B. Reassure him that an early diagnosis would not have altered his wife's prognosis
- C. Advise him to publicise his concerns in the local paper
- D. Advise him to contact the Health Service Ombudsman
- E. Advise him to make a written complaint to the surgery

Next question

When patients or their relatives feel that they have received inadequate care the first step is to try and achieve local resolution. Speaking to the health care professionals involved can often resolve any misunderstandings. If this does not resolve the issue the next step[is for the patient or family to make a formal written complaint.

If local resolution fails then the next step is to involve a more central body such as the Health Service Ombudsman. All complaints should be acknowledged and not played down, regardless of whether it has altered a patient's long-term prognosis.

Advising a patient to contact the local paper is not likely to result in a resolution to the situation.

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Rate question:

Next question

Comment on this question

Question stats

A	63.5%
B	9.6%
C	0.3%
D	0.7%
E	26%

63.5% of users answered this question correctly

Session score = 0%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

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Question 38 of 165

Which one of the following statements regarding practice based commissioning (PBC) is incorrect?

- A. Any savings made through PBC is an extra source of income for partners
- B. The PCT will be responsible for placing and managing contracts
- C. The PCT will continue to hold the actual funds for commissioning
- D. Practices are encouraged to form commissioning groups
- E. Devolves responsibility for commissioning services from Primary Care Trusts (PCTs) to GPs

Next question

Savings made through PBC can only be spent on patient services and 'should be used to improve clinical services in a substantial way'

Practice based commissioning

Practice based commissioning (PBC) is a Department of Health (DoH) initiative to 'engage practices and other primary care professionals in the commissioning of services'. It is also hoped that with PBC 'front line clinicians are being provided with the resources and support to become more involved in commissioning decisions'.

In real terms this means devolving responsibility for commissioning services from Primary Care Trusts (PCTs) to local GP practices in a hope to save money. Ultimately practices would be given a budget for commissioning services. This will involve:

- identifying patient needs
- designing effective and appropriate health service responses to those needs
- allocating resources against competing service priorities

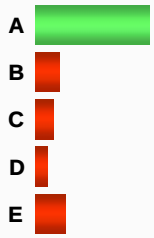
The actual financial implications for practices are complicated. The budget will be an 'indicative' budget only. The PCT will continue to hold the actual funds and will still be responsible for placing and managing contracts. If a practice overspends their indicative budget they will be expected to make a saving over the following years to achieve an overall balance. If practices join together into commissioning groups they would be able to 'spread the risk' and be less vulnerable to random fluctuations in activity.

Savings made through PBC can only be spent on patient services and 'should be used to improve clinical services in a substantial way'

Potential disadvantages

- increased bureaucracy for GPs
- conflict of interest: GPs may have perverse incentives to avoid taking on 'costly' patients or under-refer or under-prescribe

Question stats



58% of users answered this question correctly

Session score = 0%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

Rate question:

Next question

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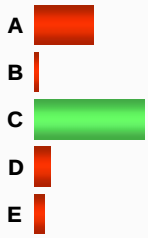
Question 39 of 165

When revalidation is introduced, how will GPs be assessed?

- A. Appraiser will perform assessment every 5 years
- B. Visit to your usual place of work by two GPs who have been trained as assessors
- ✓ C. Submission of an electronic portfolio for review by a Responsible Officer
- D. Submission of an electronic portfolio for review by a panel of GPs (ideally from the local area)
- E. Interview with a panel of assessors including a GP and a lay person, similar to the current RITA process

Next question

Question stats



55.9% of users answered this question correctly

Session score = 0%

Revalidation

Revalidation introduces a change in the way doctors are licensed and certificated. Currently UK doctors automatically receive their licence to practise if they have paid their annual fee and have no limitations on their registration (e.g. Following a GMC ruling). To practise as a GP doctors must also be on the GP Register - a process known as certification.

Following the introduction of revalidation doctors will be required to prove their fitness to practise to allow them to continue to work as a doctor. Revalidation will occur every 5 years and in one process combine relicensing and recertification. Annual appraisals will continue as before but there will be a focus on whether the doctor is making sufficient progress towards their revalidation portfolio.

The type and amount of evidence required will be similar to that needed for appraisals currently. The RCGP is creating an ePortfolio for the process and proposes that it should contain the following (please see the link for more details):

- description of your work
- description of any special circumstances (e.g. Prolonged illness)
- details of previous appraisals
- current personal development plan
- review of previous personal development plans
- evidence of continuing professional development - at least 50 'learning credits' are required per year
- multi-source feedback
- patient questionnaire surveys
- significant event audits
- review of any formal complaints
- probity/health statements

Learning credits

RCGP curriculum

3.1 - Clinical Governance

Curriculum statement

External links

RCGP
Revalidation

- minimum of 1 credit for each hour of education
- however, if the hour of education can be shown to lead to improvements in patient care then it will count as 2 credits

Submitting the evidence for revalidation

- the ePortfolio will be submitted electronically for review
- the review will be done by a 'Responsible Officer'
- the Responsible Officer is likely to be advised by a GP assessor and a trained lay person
- if the submitted evidence is considered sufficient the Responsible Officer will recommend to the GMC that the doctor is both relicensed and recertificated

Revalidation is due to be phased in from 2011 to 2016.

Rate question:

Next question

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Question 40 of 165

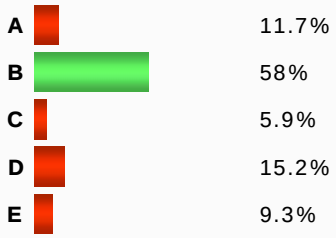
Which one of the following statements regarding Disability Living Allowance (DLA) is incorrect?

- A. Is for patients under the age of 65 years
- ✓ B. Has three components - care, mobility and housing
- C. Is tax-free
- D. Is not means tested
- E. Patients should normally be likely to need help for at least a further 6 months

Next question

Disability Living Allowance has two components - care and mobility

Question stats



58% of users answered this question correctly

Session score = 0%

Benefits: chronic illness and cancer patients

Patients who have a chronic illness or cancer, which results in a disability severe enough to need help with caring for themselves, are entitled to claim the following benefits:

- Disability Living Allowance: for patients under the age of 65 years
- Attendance Allowance: for patients over aged 65 years and over

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

Disability Living Allowance

Disability Living Allowance (DLA) can be claimed by patients who normally have needed help for at least 3 months and be likely to need it for at least a further 6 months. It is tax-free, not means tested and divided into two components:

- Care component
- Mobility component

Attendance Allowance

Attendance Allowance (AA) is a tax-free allowance for people aged 65 or over when they claim who need help with their personal care. To claim AA patients should normally have needed help with care for 6 months. Like DLA it is not means tested

Terminally ill patients

Patients who have a terminal illness (where there is an expectation that the patient will not live for more than 6 months) are eligible to be fast-tracked through the system for claiming DLA or AA. A **DS1500** form is completed which ensures the application is dealt with promptly and that the patient automatically receives the higher rate

Rate question:

Next question

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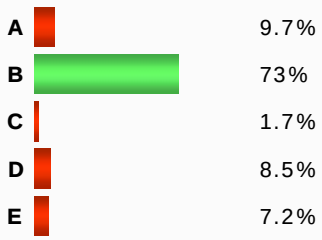
Question 41 of 165

Of the following scenarios, which one would indicate it was inappropriate for the patient to take an airline flight?

- A. A 54-year-old woman who had a laparoscopic cholecystectomy 5 days ago
- ✓ B. A 17-year-old flying back to the UK who broke his leg whilst skiing in Canada. Had a plaster cast applied 24 hours ago
- C. A 59-year-old man who had a colonoscopy 2 days ago
- D. A 62-year-old man who had an uncomplicated myocardial infarction 3 weeks ago
- E. A woman who is 27-weeks pregnant with twins

Next question

Question stats



73% of users answered this question correctly

Session score = 0%

Following the application of a plaster cast patients should wait 24 hours before short flights (< 2 hours) and 48 hours before longer flights. This is due to the fact that air may be trapped beneath the cast

Fitness to fly

The Civil Aviation Authority (CAA) has issued guidelines on air travel for people with medical conditions; please see the link provided.

Cardiovascular disease

- unstable angina, uncontrolled hypertension, uncontrolled cardiac arrhythmia, decompensated heart failure, severe symptomatic valvular disease: should not fly
- uncomplicated myocardial infarction: may fly after 7-10 days
- complicated myocardial infarction: after 4-6 weeks
- coronary artery bypass graft: after 10-14 days
- percutaneous coronary intervention: after 5 days

Respiratory disease

- pneumonia: should be 'clinically improved with no residual infection'
- pneumothorax: absolute contraindication, the CAA suggest patients may travel 2 weeks after successful drainage if there is no residual air. The British Thoracic Society used to recommend not travelling by air for a period of 6 weeks but this has now been changed to 1 week post check x-ray

Pregnancy

- most airlines do not allow travel after 36 weeks for a single pregnancy and after 32 weeks for a multiple pregnancy
- most airlines require a certificate after 28 weeks confirming that the pregnancy is progressing normally

External links

Civil Aviation Authority
Fitness to fly guidelines

Surgery

- travel should be avoided for 10 days following abdominal surgery
- laparoscopic surgery: after 24 hours
- colonoscopy: after 24 hours
- following the application of a plaster cast, the majority of airlines restrict flying for 24 hours on flights of less than 2 hours or 48 hours for longer flights

Haematological disorders

- patients with a haemoglobin of greater than 8 g/dl may travel without problems (assuming there is no coexisting condition such as cardiovascular or respiratory disease)

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Questions 42 to 44 of 165

Theme: DVLA: drug and alcohol misuse

A No need to notify DVLA
B Notify DVLA but can continue to drive
C Cannot drive unless controlled for 3 months
D Cannot drive unless controlled for 6 months
E Cannot drive unless controlled for 9 months
F Cannot drive unless controlled for 12 months
G Cannot drive unless controlled for 18 months

For each of the following scenarios select the most appropriate advice regarding driving a car:

42. A 23-year-old man who smokes cannabis every day. On further discussion he says he never smokes before driving.

No need to notify DVLA

The correct answer is Cannot drive unless controlled for 6 months

43. A 45-year-old woman who is a self-confessed alcoholic. She drinks around 90 units per week and often drinks in the morning.

No need to notify DVLA

The correct answer is Cannot drive unless controlled for 12 months

44. A 29-year-old publican who drinks around 80 units per week. He denies having a drinking problem but says he drinks to relax and never before driving. His MCV and gamma-GT and mildly elevated.

No need to notify DVLA

The correct answer is Cannot drive unless controlled for 6 months

This behaviour would be classified as alcohol misuse by the DVLA

Next question

Question stats

Average score for registered users:

42	30.2%
43	43.6%
44	32.2%

Session score = 0%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

External links

DVLA
DVLA guidelines

DVLA: drug and alcohol misuse

The guidelines below relate to car/motorcycle use unless specifically stated. For obvious reasons, the rules relating to drivers of heavy goods vehicles tend to be much stricter

Alcohol misuse*

- 'persistent alcohol misuse, confirmed by medical enquiry and/or by evidence of otherwise unexplained abnormal blood markers, requires licence revocation or refusal until a minimum **6 month** period of controlled drinking or abstinence has been attained, with normalisation of blood parameters'

Alcohol dependency

- as above but **1 year**

Cannabis, amphetamines, ecstasy, LSD

- 'persistent use of or dependency on these substances, confirmed by medical enquiry, will lead to licence refusal or revocation for a minimum **6 month** period free of such use has been attained. Independent medical assessment and urine screen arranged by DVLA, may be required'

Heroin, cocaine, methadone

- as above but **1 year**, also consultant report may be required on reapplication

*this is defined by the DVLA as 'a state which, because of consumption of alcohol, causes disturbance of behaviour, related disease or other consequences, likely to cause the patient, his/her family or society harm now, or in the future, and which may or may not be associated with dependency'

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Question 45 of 165

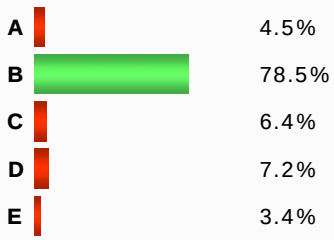
How long should a patient stop driving for following a stroke?

- A. No restriction unless physical/visual impairment
- ✓ B. 1 month
- C. 3 month
- D. 6 months
- E. 12 months

Next question

DVLA advice post stroke or TIA: cannot drive for 1 month

Question stats



78.5% of users answered this question correctly

Session score = 0%

DVLA: neurological disorders

The guidelines below relate to car/motorcycle use unless specifically stated. For obvious reasons, the rules relating to drivers of heavy goods vehicles tend to be much stricter

Specific rules

- first seizure: 6 months off driving*. For patients with established epilepsy they must be fit free for 12 months before being able to drive
- stroke or TIA: 1 month off driving
- multiple TIAs over short period of times: 3 months off driving
- craniotomy e.g. For meningioma: 1 year off driving**
- pituitary tumour: craniotomy: 6 months; trans-sphenoidal surgery 'can drive when there is no debarring residual impairment likely to affect safe driving'
- narcolepsy/cataplexy: cease driving on diagnosis, can restart once 'satisfactory control of symptoms'

Syncope

- simple faint: no restriction
- unexplained, low risk of recurrence: 4 weeks off
- explained and treated: 4 weeks off
- unexplained: 6 months off

*previously rule was 12 months. It is now 6 months off driving if the licence holder has undergone assessment by an appropriate specialist and no relevant abnormality has been identified on investigation, for example EEG and brain scan where indicated

**if the tumour is a benign meningioma and there is no seizure history, licence

RCGP curriculum

15.7 - Neurological Problems

Knowledge

Curriculum statement

External links

DVLA
Neurological disorder guidelines

can be reconsidered 6 months after surgery if remains seizure free

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Question 46 of 165

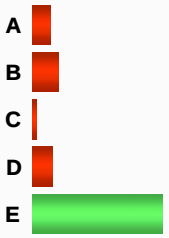
When prescribing the following drugs, which one requires the prescription to state the total quantity in both words and figures?

- A. Oral zolpidem
- B. Oral diazepam
- C. Oral risperidone
- D. Subcutaneous somatropin
- ✓ E. Buccal midazolam

Next question

The legal status of midazolam changed in January 2008 to a Schedule 3 controlled drug

Question stats



66% of users answered this question correctly

Session score = 0%

Controlled drugs

When prescribing a controlled drug the following must be present on the prescription:

- name and address of the patient
- the form, and where appropriate the strength, of the preparation

- either the total quantity (in both words and figures) of the preparation, or the number (in both words and figures) of dosage units to be supplied

- the dose (cannot write 'as directed')
- prescribers name, signature, address and current date

The 2001 Misuse of Drugs Regulations act defines who is authorised to prescribe controlled drugs. It divided drugs of potential abuse into 5 categories ('schedules') each with own rules on prescribing, supply, possession, record keeping etc

Schedule 1	Cannabis, lysergide
Schedule 2	Diamorphine, morphine, pethidine, amphetamine, cocaine
Schedule 3	Barbiturates, buprenorphine, midazolam*, temazepam**
Schedule 4	**Part 1**: Benzodiazepines (except midazolam and temazepam) and zolpidem **Part 2**: Androgenic and anabolic steroids, hCG, somatropin Controlled drug prescription requirements do not apply and Schedule 4 controlled drugs are not subject to safe custody requirements
Schedule 5	Includes preparations which because of their strength are exempt from the vast majority of Controlled Drug requirements other than retention of

RCGP curriculum

3.2 - Patient Safety

Curriculum statement

External links

UK Government
Misuse of Drugs Regulations 2001

	invoices (e.g. Oramorph 10mg/5ml)

Further selected points

- Schedule 2 and 3 drugs are marked 'CD' in the BNF
- a prescription for controlled drugs in Schedules 2,3 & 4 is valid for 28 days
- a pharmacist is generally not allowed to dispense unless all the information required by law is given. With Schedule 2 and 3 drugs a pharmacist is allowed to amend the prescription if 'it specifies the total quantity only in words or in figures or if it contains minor typographical errors, provided that such amendments are indelible and clearly attributable to the pharmacist making them'

*midazolam was changed from schedule 4 to 3 in 2008

**temazepam is excluded from the prescription requirements

Rate question:

Next question

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Question 47 of 165

Which one of the following IT systems calculates how well a practice is doing in meeting the Quality and Outcomes Framework (QOF) targets and hence determines a practices QOF income?

- A. QOFSR
- B. QOF-SNOMED
- C. Qsys
- D. QMAS
- E. PRODIGY

Next question

Question stats

A	7.9%
B	34.3%
C	2.3%
D	42.1%
E	13.3%

42.1% of users answered this question correctly

Session score = 0%

QMAS

The Quality Management and Analysis System (QMAS) is a national IT programme which provides practices and primary care trusts with information on how well individual practices are meeting the Quality and Outcomes Framework (QOF) targets. QMAS calculates a points score which will determine a practices QOF income

RCGP curriculum

4.2 - Information Management and Technology

Curriculum statement

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Next question

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Question 48 of 165

A 20-year-old student from India asks to register at the surgery. Which one of the following is correct?

- A. He cannot register unless he has already lived for more than 6 months in the UK
- B. He cannot register unless he has already lived for more than 12 months in the UK
- C. He is not entitled to NHS primary care but should be advised to attend A&E if acutely unwell
- D. He cannot register unless he plans to live in the UK for more than 12 months
- ✓ E. He cannot register unless he plans to live in the UK for more than 6 months

Next question

Question stats

A	6.4%
B	0.6%
C	6.7%
D	4.5%
E	81.8%

81.8% of users answered this question correctly

Session score = 0%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

External links

Department of Health
Eligibility for free hospital treatment under the NHS

NHS treatment eligibility

Primary care

People are eligible for primary care if they are 'ordinarily resident' in the UK. Contrary to popular belief it is not related to National Insurance contributions or nationality. This generally means they will be in the UK for at least 6 months but it should be noted that there is no qualifying period (i.e. People are entitled to care if they expect to be in the UK for 6 months). This would exclude people who have emigrated but return every so often for free NHS care. Refugees are regarded as ordinarily resident.

Secondary care

The following hospital treatment is free of charge for everyone who needs it, regardless of how long they have been or intend to stay in the UK:

- contraception
- accident and emergency department treatment (excludes emergency treatment given elsewhere in the hospital)
- compulsory psychiatric treatment
- treatment for certain communicable diseases, e.g. Tuberculosis, malaria and meningitis. Testing for HIV is free of charge, but any subsequent treatment may have to be paid for

Visitors can receive NHS hospital treatment free of charge if the need for treatment
arose during their visit to the UK and:

- person is a national of an European Economic Area (EEA) country* or Switzerland
- person normally lives abroad, and is receiving a UK state pension, and has

lived in the UK in the past for at least ten years
- person has lived in the UK for at least ten years in the past, but now lives in an EEA state, or in a non-EEA state with which the UK has a reciprocal agreement
- person is a national, or a resident of certain non-EEA countries, with which the UK has a reciprocal agreement.

*European Union countries plus Liechtenstein, Iceland and Norway

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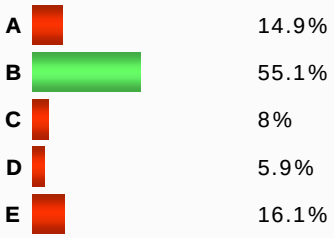
Question 49 of 165

Which one of the following statements regarding GP contracts is true?

- A. PMS practices receive a Minimum Practice Income Guarantee (MPIG)
- ✓ B. PMS practices may take part in the QOF scheme
- C. Doctors in GMS practices tend to earn more than those in PMS practices
- D. The majority of practices are PMS
- E. The GMS contract is locally negotiated

Next question

Question stats



55.1% of users answered this question correctly

Session score = 0%

GP contract: comparison

The table below summarises some of the basic differences the General Medical Services (GMS), Personal Medical Services (PMS) and Alternative Provider Medical Services contracts:

	GMS	PMS	APMS
Who can provide services?	GP / qualifying health professional or company 100% owned by qualifying persons	GP / qualifying health professional or company 100% owned by qualifying persons	No restriction of providers
Contract - negotiation	Nationally negotiated	Locally negotiated with mandatory terms	Locally negotiated with mandatory terms
Contract - scope	Essential services (e.g. day-to-day care) with optional additional services (e.g. Minor surgery) and enhanced services	Core and additional services (similar to GMS)	Depends on individual contract
Contract - type	Open-ended which cannot be terminated unless fault proven	Usually for five years, contract may be terminated	Usually for three years, contract may be terminated
Payment	Global sum with Minimum Practice Income Guarantee (MPIG), QOF, enhanced services, premises, IT	Baseline set nationally, QOF	Locally negotiated
General	The majority of practices are	GPs in PMS tend to	

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

	GMS	have higher incomes	

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Question 50 of 165

Which one of the following is not an integral part of clinical governance?

- A. Health promotion
- B. Clinical audit
- C. Risk management
- D. Clinical effectiveness
- E. Education and training of staff

Next question

Health promotion is obviously important but is not under the remit of clinical governance

Clinical governance

Clinical governance may be defined as 'the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish'

It comprises a number of elements:

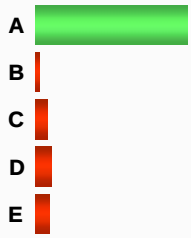
- education and training
- clinical audit
- clinical effectiveness
- research and development
- risk management
- openness

Rate question:

Next question

Comment on this question

Question stats



76.6% of users answered this question correctly

Session score = 0%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

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Question 51 of 165

A friend of yours who is a doctor asks you to prescribe him a course of ciprofloxacin as he is going to Goa on holiday in three days time. What is the most appropriate action?

- A. Inform the GMC of his conduct
- ✓ B. Decline and suggest he consults with his regular GP
- C. Briefly ascertain any past medical history and advise him that taking ciprofloxacin is not normally recommended
- D. Prescribe the ciprofloxacin for him
- E. Advise him to go to A&E for a prescription

Next question

The GMC have the following to say on prescribing to people you know:
'Doctors should, wherever possible, avoid treating themselves or anyone with whom they have a close personal relationship and should be registered with a GP outside their family.'

Therefore the best option is to advise him to see his own GP. Getting into a discussion about his past medical history is problematic as it blurs the boundaries of being a doctor or a friend. Advising him to go to A&E is a poor option as it is neither an accident nor an emergency.

This is not an uncommon request from colleagues, therefore informing the GMC seems very harsh.

_

Rate question:

Next question

Comment on this question

Question stats

A	0.4%
B	89.1%
C	7.2%
D	2.5%
E	0.8%

89.1% of users answered this question correctly

Session score = 0%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

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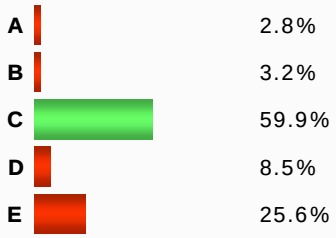
Question 52 of 165

Which one of the following statements regarding the Statement of Fitness for Work is correct?

- A. The statement can no longer be used for benefit purposes
- B. It may be completed by a registered Nurse Practitioner
- ✓ C. It may be completed following a telephone consultation in the first instance
- D. Replaces the old Med4 and Med6 forms
- E. Includes an option to state that the patient is fit to return to work

Next question

Question stats



59.9% of users answered this question correctly

Session score = 0%

Statement of Fitness for Work

In 2010 sick notes became fit notes, or more formally the Statement of Fitness for Work. They have been introduced to reflect the fact that in the majority of cases patients do not need to be 100% fit before returning to work. The major change is allowing a doctor to advise that a patient 'may be fit for work taking account of the following advice'.

This information is taken from the Department of Work and Pensions website. Please see the link for further details.

Other changes

- the Statement of Fitness for Work replaces the Med3 and Med5 in one form
- the Med4, Med6 and RM 7 forms have been withdrawn due to the replacement of Incapacity Benefit with the Employment and Support Allowance
- telephone consultations are now an acceptable form of assessment
- there is no longer a box to say a patient is fit for work. There is however an option to state if you need to assess your patient's fitness for work again at the end of the statement period
- there is increased space for comments on the functional effects of the condition, including tick boxes for simple things that may help a patient back to work
- during the first 6 months of an illness the new statement can be issued for no longer than 3 months.. After this time it may be issued for an indefinite period

Things that stay the same

- can only be completed by a doctor
- you can still the advise a patient that they are not fit for work (of any type)
- the advice on the statement is not binding on employers

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

External links

Department of Work and Pensions
Statement of Fitness for Work

The statement may be issued:

- on the day that you assessed the patient
- on a date after you assessed your patient if you consider that it would have been reasonable to issue a statement on the day of the assessment
- after consideration of a written report from another doctor or registered health care professional

There are 4 'tick boxes' included on the form which represent common approaches to aid a return to work. One or more may be ticked. Other approaches can be suggested in the comments box. The options are:

- a phased return to work
- altered hours
- amended duties
- workplace adaptations

Patients may self-certify for the first 7 calendar days:

SC1	Self-certification, for patients not eligible to claim statutory sick pay (e.g. Unemployed or self-employed). For the first 7 calendar days of an illness
SC2	The 'standard' self-certification form, for patients eligible to claim statutory sick pay. For the first 7 calendar days of an illness

Rate question:

Next question

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Questions 53 to 55 of 165

Theme: DVLA: cardiovascular disorders

A No restriction
B 1 week off driving
C 2 weeks off driving
D 4 weeks off driving
E 6 weeks off driving
F 2 months off driving
G 3 months off driving
H No restriction but inform DVLA

For each of the following scenarios select the most appropriate advice regarding driving a car:

53. A 71-year-old man has just had a permanent pacemaker insertion

No restriction

The correct answer is 1 week off driving

54. A 61-year-old man has an uneventful coronary artery bypass graft

No restriction

The correct answer is 4 weeks off driving

55. An implantable cardioverter-defibrillator has just been inserted into a patient with hypertrophic obstructive cardiomyopathy who has never had a ventricular arrhythmia

No restriction

The correct answer is 4 weeks off driving

Next question

Question stats

Average score for registered users:

53	61.4%
54	64.6%
55	33.3%

Session score = 0%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

External links

DVLA
Cardiovascular disorder guidelines

DVLA: cardiovascular disorders

The guidelines below relate to car/motorcycle use unless specifically stated. For obvious reasons, the rules relating to drivers of heavy goods vehicles tend to be much stricter

Specific rules

- angioplasty (elective) - 1 week off driving
- CABG - 4 weeks off driving
- acute coronary syndrome- 4 weeks off driving, 1 week if successfully treated by angioplasty
- angina - driving must cease if symptoms occur at rest/at the wheel
- pacemaker insertion - 1 week off driving
- implantable cardioverter-defibrillator: if implanted for sustained ventricular arrhythmia: cease driving for 6 months. If implanted prophylatically then cease driving for 1 month
- successful catheter ablation for an arrhythmia- 2 days off driving
- aortic aneurysm of 6cm or more - notify DVLA. Licensing will be permitted subject to annual review. An aortic diameter of 6.5 cm or more disqualifies patients from driving
- heart transplant: DVLA do not need to be notified

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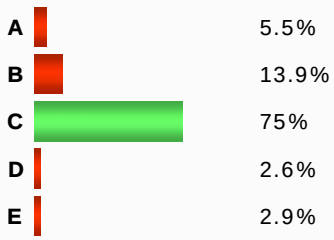
Question 56 of 165

How long is bereavement allowance paid for following the death of a spouse?

- A. 3 months from the date of death
- B. 6 months from the date of death
- ✓ C. 12 months from the date of death
- D. 18 months from the date of death
- E. 24 months from the date of death

Next question

Question stats



75% of users answered this question correctly

Session score = 0%

Benefits: bereavement

Whilst GPs are not supposed to be experts on claimable benefits, a rough understanding is expected

Funeral payment	One-off payment to the partner or parent of the deceased if they are on benefits to help pay for a funeral
Bereavement payment	Lump sum given to spouse if they are under the state pension age when their partner died Depends on national insurance contributions Not payable to divorcees
Bereavement allowance	Taxable weekly benefit paid to the spouse for up to 52 weeks from the date of death, if the surviving partner is 45 years or older and less than the state pension age
Widowed Parent's Allowance	Payable to a parent whose husband or wife has died. Eligibility • surviving partner is bringing up a child < 19 years of age and receiving child benefit • deceased partner had made adequate national insurance contributions • also if the woman was expecting her late husband's baby • divorcees and those who remarry and not eligible to claim

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

External links

DirectGov
Bereavement benefits

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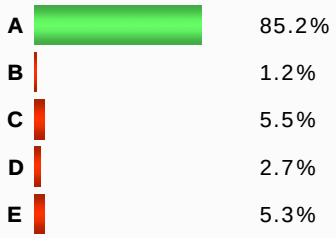
Question 57 of 165

Which one of the following medical conditions does not allow a patient to apply for a prescription exemption certificate?

- A. Psoriasis
- B. Addison's Disease
- C. Diabetes insipidus
- D. Myasthenia gravis
- E. Hypoparathyroidism

Next question

Question stats



85.2% of users answered this question correctly

Session score = 0%

Prescription charges

The following information applies to England. Wales has abolished prescription charges and Scotland plans to remove prescription charges altogether by 2011.

Who is entitled to free prescriptions?

- children (< 16 years old)
- aged 16, 17 or 18 and in full-time education
- elderly (aged 60 or over)
- if the patient or their partner receives: income support or jobseeker's allowance
- if the patient has a prescription exemption certificate

Prescription exemption certificate

Women who are pregnant or have had a child in the past year are entitled to free prescriptions after the issuing of a prescription exemption certificate. Patients who have the following chronic medical conditions are also entitled:

- hypoparathyroidism
- hypoadrenalism for which specific substitution therapy is essential (e.g. Addison's Disease)
- diabetes insipidus and other forms of hypopituitarism
- diabetes mellitus except where treatment is by diet alone
- myasthenia gravis
- hypothyroidism requiring thyroid hormone replacement
- epilepsy requiring continuous anti-convulsive therapy
- a permanent fistula requiring continuous surgical dressing or requiring an appliance
- undergoing treatment for cancer. This includes treatment for the effects of cancer or for the effects of cancer treatments

Pre-payment certificate

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

Pre-payment certificates (PPC) are for patients not entitled to free prescriptions but who receive frequent prescriptions. They are cheaper if the patient pays for more than 14 prescriptions per year

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Next question

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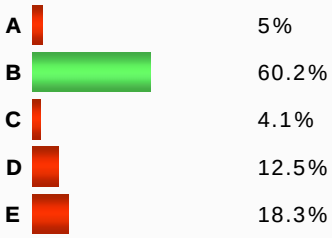
Question 58 of 165

Which one of the following statement regarding the 2005 Mental Capacity Act is incorrect?

- A. Patients with Down's syndrome should be assumed to have capacity
- ✓ B. Applies to patients of any age
- C. Patients who are schizophrenic should be assumed to have capacity
- D. The views of family members should be sought when assessing a patients best interests
- E. Applies to a patient who is suffering a temporary impairment

Next question

Question stats



60.2% of users answered this question correctly

Session score = 0%

The Mental Capacity Act does not apply to children. All patients should be assumed to have capacity, regardless of diagnosis, until proven otherwise

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

Mental Capacity Act

The Mental Capacity Act of 2005 came into force in 2007. It applies to adults over the age of 16 and sets out who can take decisions if a patient becomes incapacitated (e.g. following a stroke). Mental capacity includes the ability to make decisions affecting daily life, healthcare and financial issues.

The Act contains 5 key principles:

- A person must be assumed to have capacity unless it is established that he lacks capacity
- A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success
- A person is not to be treated as unable to make a decision merely because he makes an unwise decision
- An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests
- Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action

Assessment of capacity

The Act sets out a clear test for assessing whether a person lacks capacity. It is a 'decision-specific' and 'time-specific' test. An adult can only be considered unable to make a particular decision if:

1. He or she has an 'impairment of, or disturbance in, the functioning of the mind or
brain' whether permanent or temporary AND

2. He or she is unable to undertake any of the following

- a. understand the information relevant to the decision
- b. retain that information
- c. use or weigh that information as part of the process of making the decision
- d. communicate the decision made by talking, sign language or other means

No individual can be labelled ‘incapable’ simply as a result of a particular medical condition. Section 2 of the Act makes it clear that a lack of capacity cannot be assumed by a person’s age, appearance, or any condition or aspect of a person’s behaviour

Best interests

The following should be considered when assessing what is in someone’s best interests:

- 1. Whether the person is likely to regain capacity and can the decision wait.
- 2. How to encourage and optimise the participation of the person in the decision.
- 3. The past and present wishes, feelings, beliefs, values of the person and any other relevant factors
- 4. Views of other relevant people

Lasting Powers of Attorney (LPAs)

The Act allows a person to appoint an attorney to act on their behalf if they should lose capacity in the future, replacing the current Enduring Power of Attorney (EPA). In addition to property and financial affairs the Act also allows people to empower an attorney make health and welfare decisions. The attorney only has the authority to make decisions about life-sustaining treatment if the LPA specifies that. Before it can be used an LPA must be registered with the Office of the Public Guardian

Advance decisions

Advance decisions can be drawn up by anybody with capacity to specify treatments they would not want if they lost capacity. They may be made verbally unless they specify refusing life-sustaining treatment (e.g. Ventilation) in which case they need to be written, signed and witnessed to be valid. Advance decisions cannot demand treatment

Rate question:

Next question

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Question 59 of 165

Which one of the following statements is not a stated duty of a doctor in the General Medical Council document 'Duties of a doctor'?

- A. Keep your professional knowledge and skills up to date
- B. Never discriminate unfairly against patients or colleagues
- ✓ C. Provide holistic care addressing patients' physical, psychological and social needs
- D. Respect patients' right to confidentiality
- E. Recognise and work within the limits of your competence

Next question

Knowledge of the GMC document 'Good Medical Practice' is a stated requirement in the nMRCGP syllabus

General Medical Council: duties of a doctor

Make the care of your patient your first concern

Protect and promote the health of patients and the public

- Provide a good standard of practice and care
- Keep your professional knowledge and skills up to date
- Recognise and work within the limits of your competence
- Work with colleagues in the ways that best serve patients' interests

Treat patients as individuals and respect their dignity

- Treat patients politely and considerately
- Respect patients' right to confidentiality

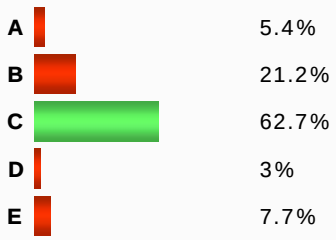
Work in partnership with patients

- Listen to patients and respond to their concerns and preferences
- Give patients the information they want or need in a way they can understand
- Respect patients' right to reach decisions with you about their treatment and care
- Support patients in caring for themselves to improve and maintain their health

Be honest and open and act with integrity

- Act without delay if you have good reason to believe that you or a colleague may be putting patients at risk
- Never discriminate unfairly against patients or colleagues
- Never abuse your patients' trust in you or the public's trust in the profession.

Question stats



62.7% of users answered this question correctly

Session score = 0%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

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Question 60 of 165

Which one of the following statements regarding visual impairment is incorrect?

- A. The patients registered GP needs to make an application to social services for blind registration
- B. Blind patients are entitled to a reduced television license fee
- C. Registration is voluntary
- D. In the UK blindness is defined as vision < 3/60 in the better eye
- E. Macular degeneration is the most common cause of severe visual impairment in the UK in the over 75s

Next question

A consultant ophthalmologist rather than a GP needs to make an application to social services

Visual impairment

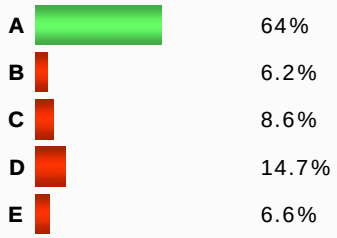
Blindness is generally defined as vision < 3/60 in the better eye. Registration is voluntary in England. Patients who are deemed blind are eligible for additional benefits (for example disabled parking badge, reduced television license fee, talking books). A consultant ophthalmologist is needed to make an application to social services

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Question stats



64% of users answered this question correctly

Session score = 0%

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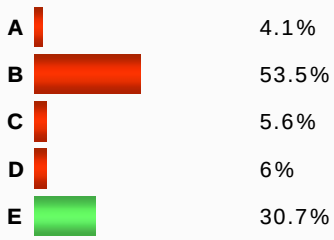
Question 61 of 165

You are reviewing the Practice policy on controlled drugs. Which type of controlled drugs must be recorded in a register?

- A. Schedules 1, 2, 3, 4 & 5
- B. Schedules 2 & 3
- C. Schedule 3
- D. Schedules 2, 3, 4 & 5
- E. Schedule 2 ✓

Next question

Question stats



30.7% of users answered this question correctly

Session score = 0%

Controlled drugs: storage and register

Storage

In the surgery controlled drugs (CDs) should be stored in a locked cabinet.

Controlled drugs outside of the surgery must be stored in a locked receptacle (combination lock or key). A doctor's bag with a lock is acceptable. It should be noted that storing a controlled drug in a locked car boot is not acceptable.

Register

A register must be kept for the supply of Schedule 2 drugs.

Specific requirements of the register:

- must be bound rather than loose leaved. Computerised records are acceptable as long as they are secure and auditable
- each drug should have its own individual section
- entries should be chronological and made in indelible ink
- the following information should be recorded when receiving CDs: date, name and address of the supplier, quantity received, name, form and strength
- the following information should be recorded when supplying CDs (either to patients or practitioners): date, name and address of the person receiving the CD, person who prescribed or ordered the CD, quantity supplied, name, form and strength
- must be kept for a minimum of 2 years after the date of the last entry

For doctor's bags a separate CD register should be kept for the CD stock held within that bag. The individual doctor is responsible for the receipt and supply of CDs from their own bag.

RCGP curriculum

4.1 - Management in Primary Care

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Question 62 of 165

You are a GP registrar. Whilst on a night-out the F2 doctor asks if you would like to go out for dinner. What is the most appropriate response?

- A. Tell the F2 doctor you would rather wait until the end of the current job before dating
- B. Ask to be moved to a different practice
- ✓ C. Make a decision based on whether you like that person or not
- D. Tell the F2 doctor you do not feel it is professional to have a relationship with a work colleague
- E. Report the doctor to the GMC

Next question

There is nothing wrong with dating a colleague! Many doctors meet their future partner whilst at work. This question looks at whether you can give a sensible, measured answer as opposed to one which you think is 'right'.

_

Rate question:

Next question

Comment on this question

Question stats

A	15%
B	0.3%
C	61%
D	23.7%
E	0.1%

61% of users answered this question correctly

Session score = 0%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

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Question 63 of 165

You are a GP registrar. The next patient has been seen at the surgery before complaining of being tired all the time. She brings in a letter from a private clinic asking you to prescribe thyroxine. In the letter the consultant explains that whilst the patient's TSH is normal the thyroxine level is at the lower end of the normal range and he feels that a trial of thyroxine is indicated to help speed up her metabolism. What is the most appropriate action?

- A. Respect the consultant's opinion and prescribe thyroxine
- ✓ B. Write a letter to the consultant asking for clarification as to why thyroxine is being prescribed
- C. Write a letter to the consultant explaining that you are not happy to prescribe thyroxine
- D. Advise the patient to sue the consultant
- E. Refer the patient to an endocrinologist on the NHS for a second opinion

Next question

Inappropriate requests for medication or treatment may occasionally be made by third parties.

The best response is to write to the consultant asking for clarification. It may be that it is a recognised/established treatment that they are requesting. This approach avoids making the mistake of presuming a treatment option is not valid simply because you have not heard of it. The next best option is to write a letter explaining that you are not happy prescribe thyroxine.

Referring the patient to a NHS consultant would hopefully ensure they receive appropriate treatment but may not be necessary or desired by the patient. Simply accepting a treatment because a third party has recommended it is a poor option as it may potentially put the patient at risk - what if the thyroxine request was a typing error?

_

Rate question:

Next question

Comment on this question

Question stats

A	13.3%
B	59.5%
C	13.3%
D	0.2%
E	13.8%

59.5% of users answered this question correctly

Session score = 0%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

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Questions 64 to 66 of 165

Theme: Benefits

A Bereavement Allowance
B Bereavement Payment
C Statutory Sick Pay
D Disability Living Allowance
E Employment and Support Allowance
F State pension
G Income Support
H Job Seekers Allowance
I No benefits claimable

For each of the following scenarios select the claimable benefit

64. A 45-year-old solicitor who works full time despite his depression

Bereavement Allowance

The correct answer is No benefits claimable

65. Regular payment to a 45-year-old accounts clerk whose wife has recently died

Bereavement Allowance

66. 66-year-old man with diabetes mellitus who works full time as a architect

Bereavement Allowance

The correct answer is State pension

Next question

Question stats

Average score for registered users:

64	77.4%
65	78.5%
66	79.8%

Session score = 1.5%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

Benefits

Whilst GPs are not supposed to be experts on claimable benefits, a rough understanding is expected

Income support	Aged 16-59 years, on low income, working less than 16 hours per week and not receiving Job Seekers Allowance
Job Seekers Allowance	From 19 years old to state pension age. Claimants must be capable of working and agree to actively seek work
Disability Living Allowance	Tax-free benefit for children and adults who need help with personal care or have walking difficulties because they are physically or mentally disabled
Statutory Sick Pay	For employees unable to work due to illness. Unable to work for > 4 days in a row. Paid up to a maximum of 28 weeks
Incapacity Benefit & Employment and Support Allowance	Employment and Support Allowance replaced Incapacity Benefit for new claimants from October 2008. Claimable by those not entitled to Statutory Sick Pay (SSP), for example self-employed, or when SSP has ended
Retirement pension	State pension may be claimed from 60 years for women and 65 years for men. State pensions are taxable and paid even if the claimant is still working
Bereavement payment	Lump sum given to spouse if they are under state pension age when their partner died Depends on national insurance contributions Not payable to divorcees
Bereavement allowance	Taxable weekly benefit paid to the spouse for up to 52 weeks from the date of death, if the surviving partner is 45 years or older and less than the state pension age
Health in Pregnancy Grant	Payable to pregnant women between the 25th week of pregnancy and expected date of delivery. One-off lump sum, patients need form signing by midwife or doctor. Due to be scrapped from the 1st January 2011.

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Question 67 of 165

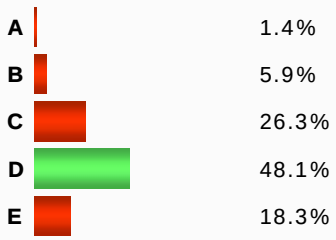
A 55-year-old accountant presents to surgery requesting a sick note following an open repair of an inguinal hernia. According to Department of Work and Pensions advice, when should he be able to return to work?

- A. After 5 days
- B. After 7 days
- C. After 1 - 2 weeks
- ✓ D. After 2 - 3 weeks
- E. After 3 - 4 weeks

Next question

Inguinal hernia repair: back to work after 2-3 weeks if open, 1-2 weeks if laparoscopic

Question stats



48.1% of users answered this question correctly

Session score = 1.5%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

Inguinal hernia

Inguinal hernias account for 75% of abdominal wall hernias. Around 95% of patients are male; men have around a 25% lifetime risk of developing an inguinal hernia.

Features

- groin lump: disappears on pressure or when the patient lies down
- discomfort and ache: often worse with activity, severe pain is uncommon
- strangulation is rare

Whilst traditional textbooks describe the anatomical differences between indirect (hernia through the inguinal canal) and direct hernias (through the posterior wall of the inguinal canal) this is of no relevance to the clinical management.

Management

- the clinical consensus is currently to treat medically fit patients even if they are asymptomatic
- a hernia truss may be an option for patients not fit for surgery but probably has little role in other patients
- mesh repair is associated with the lowest recurrence rate

The Department for Work and Pensions recommend that following an open repair patients return to non-manual work after 2-3 weeks and following laparoscopic repair after 1-2 weeks

Complications

- early: bruising, wound infection
- late: chronic pain, recurrence

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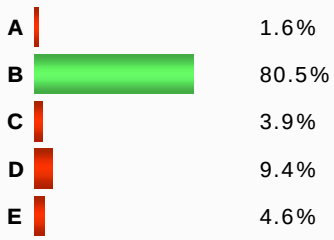
Question 68 of 165

The wife of a 75-year-old man who died at home following a long illness with lung cancer phones for advice. You have just completed the death certificate. She is asking what the next step is. What is the most appropriate advice?

- A. She should notify the police of the death then collect the death certificate from the surgery and take it to the Funeral Directors
- ✓ B. She should collect the death certificate from the surgery and take it to the local Registrar of Births, Deaths, and Marriages office
- C. You will send a copy to the Coroner's Office who will then send her the certificate for Burial or Cremation
- D. She should collect the death certificate from the surgery and take it to the Funeral Directors
- E. You will send a copy to the Coroner's Office who will then send her an appointment for the local Registrar of Births, Deaths, and Marriages office

Next question

Question stats



80.5% of users answered this question correctly

Session score = 1.5%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

External links

Home Office
Guidance for doctors completing Medical Certificates

Ministry of Justice
Cremation guidelines

Death certification

There is no legal definition of death in the UK although guidelines exist. Current guidance states 'death should be verified by a doctor, or other suitably qualified personnel' which means staff such as nurse practitioners may verify (but not certify) death.

After a patient has died a doctor needs to complete a medical certificate of cause of death (MCCD). There is a list of circumstances in which a doctor should notify the Coroner prior to completing the MCCD.

Some specific points on completing the MCCD:

- 'old age' as 1a is only acceptable if the patient was at least 80 years of age . It can be used if certain conditions are met but is discouraged
- 'natural causes' is not acceptable
- organ failure (e.g. 'liver failure') can only be used if you specify the disease or

condition that led to the organ failure (e.g. 1b: Hepatitis C)

- abbreviations should be avoided (except HIV and AIDS*)

The family then take the MCCD to the local Registrar of Births, Deaths, and Marriages office to register the death. If the Registrar decides that the death does not need reporting to the Coroner he/she will issue:

- certificate for Burial or Cremation
- certificate of Registration of Death (for Social Security purposes)
- if requested. Copies of the Death Register (banks and insurance companies

expect to see them)

If the family would like the burial to be outside of England, an Out of England Order is needed from the coroner.

*why this is I'm not sure - probably due to how well known the terms are amongst the general public

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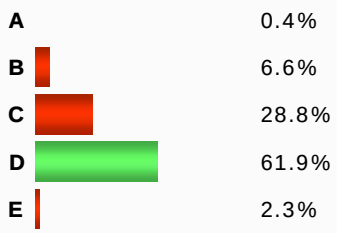
Question 69 of 165

During a consultation the patient mentions that his main source of income is illegally importing alcohol from France to the UK. What is the most appropriate action?

- A. Order some alcohol for the Christmas party – if he refuses contact the police
- B. Advise him on medical issues but inform him that you have no choice but to phone the police as soon as he leaves the room
- C. Advise him to refrain from importing alcohol and arrange a follow-up appointment
- ✓ D. Advise him on medical issues but take no further action
- E. Phone Crimestoppers anonymously to maintain the doctor-patient relationship

Next question

Question stats



61.9% of users answered this question correctly

Session score = 1.4%

This question is about judgement and the boundaries of the doctor's role.

Doctors are only required to break confidentiality and inform the police to prevent serious crime; illegally importing alcohol would not constitute a serious crime. Your role should therefore be confined to providing advice on medical issues. Advising him to refrain from importing alcohol may seem reasonable but the patient may interpret this as judgemental and it hence may interfere with the doctor-patient relationship.

Contacting the police is not appropriate as it breaks confidentiality without just cause. Phoning Crimestoppers anonymously is even worse.

It is difficult to envisage a worse response than to blackmail him in order to obtain alcohol for the Christmas party!

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

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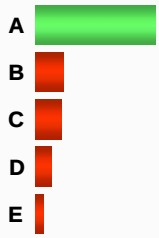
Question 70 of 165

Which one of the following consultation modes may be summarised as a 'meeting between two experts'?

- A. Tuckett ✓
- B. Calgary-Cambridge
- C. Fraser
- D. Pendleton
- E. Neighbour

Next question

Question stats



61% of users answered this question correctly

Session score = 1.4%

Consultation models

Calgary-Cambridge observation guide- Kurtz and Silverman - 1996

- initiating the session
- gathering information
- building the relationship
- giving information, explaining and planning
- closing the session

Stewart - patient-centred clinical method - 1995. 2003

- exploring both the disease and the illness experience
- understanding the whole person
- finding common ground
- incorporating prevention and health promotion
- enhancing the doctor-patient relationship
- being realistic (with time and resources)

Pendleton - The Consultation: an Approach to Learning and Teaching - 1984, 2003

- define the reason for the patient's attendance (ideas, concerns and expectations)
- consider other problems
- with the patient, choose an appropriate action for each problem
- achieve a shared understanding of the problems with the patient
- involve the patient in the management and encourage him/her to accept appropriate responsibility
- use time and resources appropriately
- establish or maintain a relationship with the patient which helps to achieve the other tasks

Fraser - Areas of competence - 1992

- interviewing and history-taking

RCGP curriculum

2 - The General Practice Consultation

Curriculum statement

- physical examination
- diagnosis and problem-solving
- patient management
- relating to patients
- anticipatory care
- record keeping

Neighbour - The Inner Consultation - five checkpoint model - 1987

- connecting
- summarising
- handing over
- safety netting
- housekeeping

Tuckett - meeting of two experts - 1985

- the consultation is a meeting between two experts
- doctors are experts in medicine
- patients are experts in their own illnesses
- shared understanding is the aim
- doctors should seek to understand the patient's beliefs
- doctors should address explanations in terms of the patient's belief system

Stott and Davis - Exceptional potential of the consultation - 1979

- management of presenting problems
- management of continuing problems
- modification of help-seeking behaviour
- opportunistic health promotion

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Question 71 of 165

Which one of the following statements regarding the Quality and Outcomes Framework (QOF) is incorrect?

- A. 5% of practices should be visited at random to help prevent fraud
- B. Participation in the QOF is voluntary
- C. For clinical indicators the value of a point is determined by the prevalence of that condition in the practice
- ✓ D. Cervical screening is an example of a clinical indicator
- E. Clinical indicators account for the majority of the points

Next question

Cervical screening is an additional service in the QOF

Question stats

A	5.7%
B	10.1%
C	15.3%
D	61.6%
E	7.3%

61.6% of users answered this question correctly

Session score = 1.4%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

Quality and Outcomes Framework

The Quality and Outcomes Framework (QOF) is the annual reward and incentive programme detailing GP practice achievement results. It was introduced as part of the new General Medical Services (GMS) to incentivise not only the management of chronic disease such as diabetes but also to improve the organisation of the practice and patient experience

Other points

- for clinical indicators the value of a point is determined by the prevalence of that condition in the practice
- participation in the QOF is voluntary
- 5% of practices should be visited at random to help prevent fraud. The PCT visiting team will normally consist of a PCT management representative, a GP and a patient representative

The table below shows the four key areas on which the QOF is based

Clinical indicators	697 points	Standards linked to the care of patients suffering from chronic diseases
Organisational	167.5 points	Standards relating to records and information, communicating with patients, education and training, medicines management and clinical and practice management
Additional services	44 points	Covering cervical screening, child health surveillance, maternity services and contraceptive services
Patient experience	91.5 points	Based on patient surveys and length of consultations

Patients may be 'exception reported' in the following situations:

- patients who have been recorded as refusing to attend review who have been invited on at least three occasions during the preceding 12 months
- patients for whom it is not appropriate to review the chronic disease parameters due to particular circumstances e.g. Terminal illness, extreme frailty
- patients newly diagnosed within the practice or who have recently registered with the practice, who should have measurements made within 3 months and delivery of clinical standards within 9 months e.g. Blood pressure or cholesterol measurements within target levels
- patients who are on maximum tolerated doses of medication whose treatment remain sub-optimal
- patients for whom prescribing a medication is not clinically appropriate e.g. Those who have an allergy, another contraindication or have experienced an adverse reaction
- where a patient has not tolerated medication
- where a patient does not agree to investigation or treatment (informed dissent), and this has been recorded in their medical records
- where the patient has a supervening condition which makes treatment of their condition inappropriate e.g. Cholesterol reduction where the patient has liver disease
- where an investigative service or secondary care service is unavailable

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Next question

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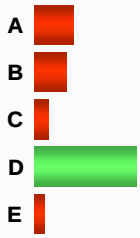
Question 72 of 165

You are designing a way of assessing Foundation year 2 doctors who are assigned to the surgery. You decide to use a combination of techniques such as patient feedback questionnaires, video consultations and case-based discussions to get a more accurate picture of the trainee. What is this an example of?

- A. Discourse analysis
- B. Quantitative research
- C. Theoretical sampling
- ✓ D. Triangulation
- E. Grounded theory

Next question

Question stats



51.5% of users answered this question correctly

Session score = 1.4%

Triangulation

Triangulation refers to the use of more than more method or approach to evaluate a process, individual or organisation. An example would be the use of multiple assessments (AKT, CSA, COTs, CEXs, patient feedback etc) when assessing a GP trainee. This decreases the likelihood that inaccurate results or outcomes are obtained due to one flawed assessment process.

RCGP curriculum

3.7 - Teaching, Mentoring, Clinical Supervision

Curriculum statement

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Question 1 of 93

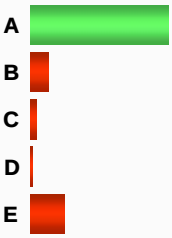
The practice nurse is off due to illness and you therefore decide to check the vaccination refridgerator. The current temperature of the fridge is +6 ºC. What is the most appropriate action?

- A. No action needed - appropriate temperature
- B. Discard all the vaccines
- C. Discard only the live vaccines
- D. Ensure all the vaccines within the fridge are used within 7 days
- E. Phone the vaccine manufacturer for advice

Next question

Vaccination refridgerator - should be +2ºC to +8ºC

Question stats



69.9% of users answered this question correctly

Session score = 100%

RCGP curriculum

3.2 - Patient Safety

Curriculum statement

External links

Greenbook
Consent

Immunisation: other aspects

As well as providing extensive information relating to individual diseases and vaccines the Greenbook also provides useful information on associated issues:

Consent

- written consent is not required
- for children not competent to give or withhold consent a person with parental responsibility may give consent on their behalf
- parental responsibility is defined by the Children Act 1989. Mothers automatically have parental responsibility. Fathers have responsibility if they are married to the mother when the child was born or subsequently marry her. Unmarried fathers may acquire parental responsibility by:
- 1. Parental Responsibility Order granted by the court
- 2. Residence Order granted by the court
- 3. Parental Responsibility Agreement
- since 2003 unmarried fathers can acquire parental responsibility if they are named on the child's birth certificate
- a step parent can can acquire parental responsibility if they marry the mother and either get a Parental Responsibility Agreement or the court grants a Parental Responsibility Order
- if parents disagree then immunisation cannot go ahead without specific court approval
- a person with parental responsibility does not need to be present at the time of immunisation. A grandparent or childminder, for example, may bring the child provided that the healthcare provider is satisfied that the person with parental responsibility has consented in advance. Written confirmation is not required.

Vaccine storage

- generally should be stored in the a fridge at **+2°C to +8°C** and kept in original packaging to protect the vaccine from UV light
- refrigerator temperature should be monitored using a maximum-minimum thermometer and recorded daily
- ordinary domestic refrigerators should not be used
- surgeries should keep no more than 2 to 4 weeks' supply of vaccines at any time

Rate question:

Next question

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Question 2 of 93

The following symbol appears in the British National Formulary:

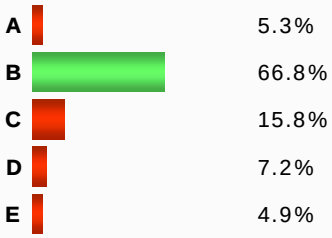


What does it mean?

- A. Prescription-only medicine
- B. Denotes a preparation that is less suitable to prescribe
- C. Newly licensed medicine
- D. Not prescribable on the NHS
- E. Controlled drug

Next question

Question stats



66.8% of users answered this question correctly

Session score = 50%

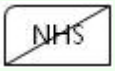
RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

British National Formulary symbols

The table below explains the meanings of the main symbols used in the BNF:

	Denotes a preparation that is less suitable to prescribe
	Newly licensed medicines
	Not prescribable on the NHS
PoM	Prescription-only medicine
CD	Controlled drug

Rate question:

Next question

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Question 3 of 93

A surgery sets up a new service where they employ a Nurse Practitioner (NP) to look after a local nursing home. The GPs do not visit unless requested to by the NPs. An 84-year-old man with dementia develops a chest infection. After the NP has had discussions with his family a decision is made to treat with oral antibiotics but not to admit. He dies two days later and his death is verified by a GP from the local out-of-hours service. What is the most appropriate action?

- A. Call the police
- B. Patients registered GP completes a death certificate, 1a 'Bronchopneumonia'
- C. Nurse Practitioner completes a death certificate, 1a 'Bronchopneumonia'
- ✓ D. Report the death to the Coroner
- E. Out-of-hours GP completes a death certificate, 1a 'Bronchopneumonia'

Next question

This patient was not seen by a doctor in the last 14 days of his illness therefore the death should be reported

Death certification

There is no legal definition of death in the UK although guidelines exist. Current guidance states 'death should be verified by a doctor, or other suitably qualified personnel' which means staff such as nurse practitioners may verify (but not certify) death.

After a patient has died a doctor needs to complete a medical certificate of cause of death (MCCD). There is a list of circumstances in which a doctor should notify the Coroner prior to completing the MCCD.

Some specific points on completing the MCCD:

- 'old age' as 1a is only acceptable if the patient was at least 80 years of age . It can be used if certain conditions are met but is discouraged
- 'natural causes' is not acceptable
- organ failure (e.g. 'liver failure') can only be used if you specify the disease or

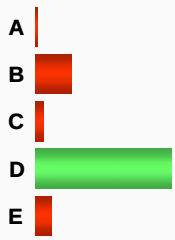
condition that led to the organ failure (e.g. 1b: Hepatitis C)

- abbreviations should be avoided (except HIV and AIDS*)

The family then take the MCCD to the local Registrar of Births, Deaths, and Marriages office to register the death. If the Registrar decides that the death does not need reporting to the Coroner he/she will issue:

- certificate for Burial or Cremation
- certificate of Registration of Death (for Social Security purposes)

Question stats



69.2% of users answered this question correctly

Session score = 33.3%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

External links

Home Office
Guidance for doctors completing Medical Certificates

Ministry of Justice
Cremation guidelines

- if requested. Copies of the Death Register (banks and insurance companies expect to see them)

If the family would like the burial to be outside of England, an Out of England Order is needed from the coroner.

*why this is I'm not sure - probably due to how well known the terms are amongst the general public

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Next question

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Question 4 of 93

The Practice Manager is concerned that the surgery is not fully compliant with the Data Protection Act. Which body must the surgery register with?

- A. Information Commissioner's Office
- B. Independent NHS Data Monitoring Office
- C. NHS Data Office
- D. Home Office
- E. Local police station

Next question

Following the 1998 the Data Protection Act all entities (e.g. a GP surgery) that process personal information must register with the Information Commissioner's Office.

Data Protection Act

The 1998 Data Protection Act is the main piece of legislation that governs the protection of personal data in the UK. The Act covers both manual and computerised records.

There are 8 main principles of the Data Protection Act:

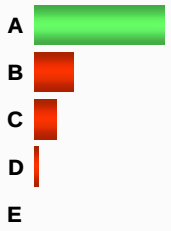
- data must be used for the specific purpose it was collected
- data must not be disclosed to other parties without the consent of the individual whom it is about
- individuals have a right of access to the information held about them
- personal information may be kept for no longer than is necessary and must be kept up-to-date
- personal information may not be transmitted outside the European Union unless consent has been given
- all entities (e.g. a GP surgery) that process personal information must register with the Information Commissioner's Office
- adequate security measures must be in place. Those include technical measures (e.g. passwords, firewalls) and organisational measures (e.g. staff training)
- subjects (i.e. patients) have the right to have factually incorrect information about them corrected

Rate question:

Next question

Comment on this question

Question stats



66% of users answered this question correctly

Session score = 25%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

External links

Information Commissioner's Office
Guidelines on recording opinions

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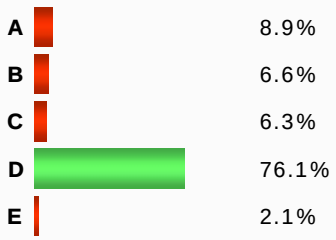
Question 5 of 93

Which one of the following statements best describes the essence of the Personal Medical Services contract?

- A. Funding follows the patient rather than the practice
- B. Practices are paid to provide core services and do not receive QOF income
- C. Run by alternative providers (e.g. Private sector) rather than GPs
- ✓ D. Local contract which reflects local patient needs
- E. A basic contract for providers who have failed to meet the standards set out by the general medical services (GMS) contract

Next question

Question stats



76.1% of users answered this question correctly

Session score = 20%

GP contract: PMS contract

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

The Personal Medical Services (PMS) contract is a locally agreed and managed contract.

The original aims of PMS were:

- to give greater freedom for GP's to address patients needs
- to encourage flexible and innovative ways of working
- to tackle under doctored areas

The contract consists of core and additional services (similar to the GMS) contract but the additional services may include things such as community endoscopy.

Specialist PMS contracts (SPMS) may be tailored to the needs of particular communities (e.g. Refugees).

GP's who have worked under the PMS contract have historically earned more than those under the GMS contract. It is likely this will be 'clawed back' in the near future.

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Next question

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Question 6 of 93

A patient is removed from the practice list following an assault on one of the receptionists. Who is responsible for organising an alternative primary care provider?

- ✓ A. The primary care trust
- B. The patient has sole responsibility
- C. The current practice
- D. The nearest alternative local practice
- E. The police

Next question

In this scenario the local primary care trust are responsible for organising alternative care. Many primary care trusts will organise specific primary care services for aggressive/violent patients.

Removing patients from the practice list

The following is based on the 2004 Royal College guidelines.

Examples of situations that may justify removal:

- unacceptable behaviour: for example violence, sexual harassment, stalking, racial abuse
- crime and deception: for example fraudulently obtaining drugs, stealing from the practice
- distance: a patient moves outside the catchment area

Examples of situations that do not normally justify removal:

- clinical matters:? patient choice, for example refusing to attend for health screening or not bringing their child for immunisations
- critical questioning and/or complaints

Removal is never justified in the following situations

- where there is an exacting or highly dependent patient, condition or disability
- patients with a high levels of anxiety or demand about perceived symptoms
- due to age, gender, ethnic origin, religion or sexual orientation

Further guidance is given on exceptional situations where there is an 'irretrievable breakdown' in the doctor-patient relationship. It is important that a formal process is agreed to try and rectify this problem rather than unilaterally declaring an irretrievable breakdown without giving any reasons to the patient.

Removing a patient from the practice list involves the following steps:

Question stats

A	68.3%
B	27.1%
C	3.4%
D	0.8%
E	0.5%

68.3% of users answered this question correctly

Session score = 33.3%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

External links

RCGP
Removing patients from the practice list guidelines

- give warning to the patient
- inform the Primary Care Trust in writing
- write to the patient

The patient's family should not be automatically removed although in practice this may be necessary.

Rate question:

Next question

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Question 7 of 93

You review a 60-year-old man who has motor neuron disease. He tells you he plans to go to Switzerland if he deteriorates as euthanasia is legal there. What is the most appropriate initial response?

- A. Inform him that it is illegal to aid anyone to commit euthanasia
- B. Reassure him that most doctors will use the 'double-effect' principle anyway to hasten the terminal phase
- C. Give him details of the appropriate clinics in Switzerland
- ✓ D. Discuss his fears about the terminal phase
- ✗ E. Suggest he contacts the Motor Neuron Disease Association so that he can talk to people in a similar situation

Next question

This issue has become increasingly relevant in recent years with a number of UK patients travelling to the 'Dignitas' clinic in Switzerland. As the law currently stands it is illegal to aid anyone to commit suicide. The best response is to explore his fears about the terminal phase. This will allow you to discuss the progress made in palliative care. It may also be beneficial if he discusses his fears with people who have experience of similar scenarios. They may be able to provide reassurance.

If he remains committed to travel to Switzerland it is appropriate to inform him of the current legal situation. Giving him details of the appropriate clinics may be seen legally as aiding suicide.

The 'double-effect' principle applies to accepting the side-effects of appropriate pain relief. It does not relate to hastening death deliberately and to give that impression is inappropriate.

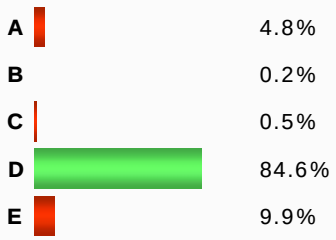
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Rate question:

Next question

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Question stats



84.6% of users answered this question correctly

Session score = 28.6%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

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Question 8 of 93

A 34-year-old is reviewed following an episode of 'collapse' whilst at church. She describes feeling hot and nauseous after standing up to sing a hymn. A few moments later she could 'feel herself going' and proceeded to fall to the ground. Her husband describes how her arms twitched at one point, but there was no tongue biting or urinary incontinence. She made a quick recovery and continued to finish the church service. Neurological examination today is unremarkable. What is the most appropriate advice regarding driving?

- A. Cannot drive for 6 months
- B. Cannot drive until investigations including ECG and neuroimaging have been performed
- ✓ C. No need to inform DVLA
- ✗ D. Cannot drive for 4 weeks
- E. Inform DVLA but can continue to drive

Next question

DVLA - simple faint - no need to inform DVLA

This is a typical history of a simple faint - there are no features to suggest epilepsy or another organic cause

DVLA: neurological disorders

The guidelines below relate to car/motorcycle use unless specifically stated. For obvious reasons, the rules relating to drivers of heavy goods vehicles tend to be much stricter

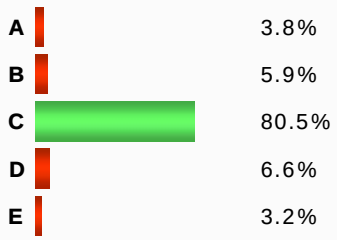
Specific rules

- first seizure: 6 months off driving*. For patients with established epilepsy they must be fit free for 12 months before being able to drive
- stroke or TIA: 1 month off driving
- multiple TIAs over short period of times: 3 months off driving
- craniotomy e.g. For meningioma: 1 year off driving**
- pituitary tumour: craniotomy: 6 months; trans-sphenoidal surgery 'can drive when there is no debarring residual impairment likely to affect safe driving'
- narcolepsy/cataplexy: cease driving on diagnosis, can restart once 'satisfactory control of symptoms'

Syncope

- simple faint: no restriction
- unexplained, low risk of recurrence: 4 weeks off
- explained and treated: 4 weeks off
- unexplained: 6 months off

Question stats



80.5% of users answered this question correctly

Session score = 25%

RCGP curriculum

15.7 - Neurological Problems

Knowledge

Curriculum statement

External links

DVLA
Neurological disorder guidelines

*previously rule was 12 months. It is now 6 months off driving if the licence holder has undergone assessment by an appropriate specialist and no relevant abnormality has been identified on investigation, for example EEG and brain scan where indicated

**if the tumour is a benign meningioma and there is no seizure history, licence can be reconsidered 6 months after surgery if remains seizure free

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Next question

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Questions 9 to 11 of 93

Theme: Scoring systems used in medicine

A Gleason score
B Bishop score
C Smith scale
D CHADS2
E ABCD2
F DAS28
G Lowsby rating
H Baxter score
I CURB-65
J Epworth scale

For each of the following please select the appropriate scoring system:

9. Used to assess the prognosis of a patient with pneumonia

Gleason score

The correct answer is CURB-65

10. Prognostic score for risk stratifying patients who've had a suspected TIA

Gleason score

The correct answer is ABCD2

11. Used to help assess the whether induction of labour will be required

Gleason score

The correct answer is Bishop score

Next question

Question stats

Average score for registered users:



Session score = 18.2%

Scoring systems

There are now numerous scoring systems used in medicine. The table below lists some of the more common ones:

CHADS2	Used to determine the need to anticoagulate a patient in atrial fibrillation
ABCD2	Prognostic score for risk stratifying patients who've had a suspected TIA
NYHA	Heart failure severity scale
DAS28	Measure of disease activity in rheumatoid arthritis
Child-Pugh classification	A scoring system used to assess the severity of liver cirrhosis
Wells score	Helps estimate the risk of a patient having a deep vein thrombosis
MMSE	Mini-mental state examination - used to assess cognitive impairment
HAD	Hospital Anxiety and Depression (HAD) scale - assesses severity of anxiety and depression symptoms
PHQ-9	Patient Health Questionnaire - assesses severity of depression symptoms
GAD-7	Used as a screening tool and severity measure for generalised anxiety disorder
Edinburgh Postnatal Depression Score	Used to screen for postnatal depression
SCOFF	Questionnaire used to detect eating disorders and aid treatment
AUDIT	Alcohol screening tool
CAGE	Alcohol screening tool
FAST	Alcohol screening tool
CURB-65	Used to assess the prognosis of a patient with pneumonia
Epworth Sleepiness Scale	Used in the assessment of suspected obstructive sleep apnoea
IPSS	International prostate symptom score
Gleason score	Indicates prognosis in prostate cancer
APGAR	Assesses the health of a newborn immediately after birth
Bishop score	Used to help assess the whether induction of labour will be required
Waterlow score	Assesses the risk of a patient developing a pressure sore
FRAX	Risk assessment tool developed by WHO which calculates a patients 10-year risk of developing an osteoporosis related fracture

Can you think of any other commonly used scoring systems?

Rate question:

Next question

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Question 12 of 93

You are a registrar in General Practice and have now been at the surgery for the past 8 months. A 57-year-old female patient comes to see you at least once a week, sometimes more often. She has a history of depression and fibromyalgia but has no other significant chronic disease. Typically she'll present with ongoing arthralgia, myalgia, low mood and pruritus. Despite extensive investigations no underlying organic cause has been found for her symptoms. She is always polite and punctual. What is the most appropriate response to this scenario?

- A. Ask her to limit visits or consider registering with another practice
- B. Tell the patient she is limited to one consultation every 2 weeks
- ✓ C. Have a conversation with the patient about her frequent attendance and suggest booking a regular appointment every two weeks initially
- D. Suggest to the patient that her frequent attendance suggests you aren't getting anywhere and that she may be better seeing another GP
- E. Take no action as mentioning her frequent visits may damage the doctor-patient relationship

Next question

This question looks at the management of a 'frequent-flyer'.

From the scenario it appears that the patient has developed an element of doctor dependence. The best option is to be honest with the patient about your observations and suggest a way of resolving the issue. One of the best approaches to this problem is to arrange regular appointments, the time between which can be gradually increased.

It is sometimes easy to forget the amount of trust and respect some patients still have for doctors. Advising her to see another doctor may seem attractive if you find the consultations tiresome but is likely to be taken personal by the patient. Artificially limiting consultations to once every 2 weeks is potentially dangerous in case the patient develops an urgent problem.

This is not grounds for removal from the practice list.

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Rate question:

Next question

Comment on this question

Question stats

A	0.4%
B	1.1%
C	88.4%
D	5.3%
E	4.7%

88.4% of users answered this question correctly

Session score = 25%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

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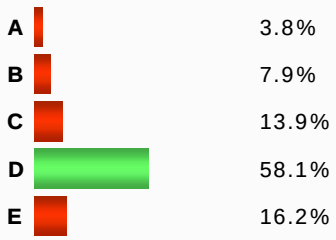
Question 13 of 93

Which one of the following drugs should be prescribed using the proprietary, rather than the generic name?

- A. Amiodarone
- B. Modified release beta-blockers
- C. Long-acting beta 2 agonists
- D. Modified release calcium channel blockers
- E. Atypical antipsychotic agents such as olanzapine

Next question

Question stats



58.1% of users answered this question correctly

Session score = 23.1%

Prescribing guidance

The BNF issues guidance on good practice when prescribing, selected points include:

- drugs should generally be prescribed by their generic name, except for certain preparations where the clinical effect may differ - please see the list below
- when writing numbers unnecessary decimal points should be avoided e.g. 250 ml not 0.25 l

Drugs which should be prescribed by brand

- modified release calcium channel blockers
- antiepileptics
- ciclosporin and tacrolimus
- mesalazine
- lithium
- aminophylline and theophylline
- methylphenidate
- CFC-free formulations of beclometasone
- dry powder inhaler devices

RCGP curriculum

3.2 - Patient Safety

Curriculum statement

Rate question:

Next question

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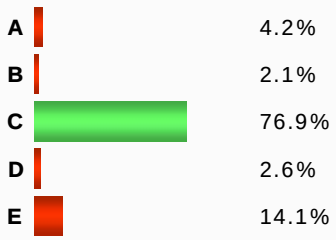
Question 14 of 93

Which one of the following statements regarding Balint groups is true?

- A. Were first started in the 1980's
- B. Are always chaired by a psychoanalyst
- ✓ C. Are suitable for GP trainees
- D. Should be no larger than five doctors
- E. The main purpose is to try and agree a patient-centred management plan

Next question

Question stats



76.9% of users answered this question correctly

Session score = 21.4%

Balint groups

Michael Balint (1896-1970) was a Hungarian psychoanalyst and psychiatrist who shaped many of the modern views on patient centred healthcare. He was primarily interested in the psychological and emotional problems that underlie many presenting complaints. His work encouraged GPs to explore these areas to understand their patients better. Balint coined the phrase 'the doctor as a drug'.

During the 1950's he established small, groups ('Balint Groups') which allowed GPs to discuss their patients on an informal basis. These are not dissimilar to discussions held amongst GP Registrars during their half-day release.

Balint's ideas were published in the book 'The doctor, his patient and the illness'.

RCGP curriculum

2 - The General Practice Consultation

Curriculum statement

Rate question:

Next question

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Question 15 of 93

Mrs Smith brings her 82-year-old mother into surgery. She is concerned that her mother is becoming increasingly forgetful. Her mother currently lives with her at the family home. Her mother becomes flustered when a mini-mental state is attempted and says she wants 'no fuss', but is unable to explain what she means by that. What is the most appropriate action?

- A. Take no further action unless the mother gives explicit consent
- ✓ B. Refer her to the memory clinic
- C. Apply for a court order
- D. Contact the police
- E. Contact social services

Next question

Question stats

A	13.1%
B	83.3%
C	0.6%
D	0.2%
E	2.8%

83.3% of users answered this question correctly

Session score = 20%

It is reasonable to presume in this scenario that the daughter is acting in the best-interests of the patient. Elderly patients with the onset of dementia are often reluctant to acknowledge that a problem exists.

The best option is therefore to refer her to the memory clinic where she can be properly assessed. The patients' inability to complete a mini-mental or explain herself indicates that it may not be appropriate to wait for explicit consent before referring her. Social services do have a role in elderly patients with dementia but there is no indication from the scenario that they need to be involved immediately.

There is no indication that a court order is required here.

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

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Rate question:

Next question

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Question 16 of 93

You are a GP registrar. A patient presents with spreading, irregular pigmented lesion on her leg. On examination it looks almost certainly to be a malignant melanoma. You tell the patient that you are concerned it may be a serious form of skin cancer. The patient replies that she doesn't believe in 'western medicine' and wants to use 'traditional remedies' such as homeopathy. How should you respond to this situation?

- A. Call her daughter to discuss the matter
- B. Refer her anyway given the severity of the diagnosis, it is her decision whether she attends or not
- C. Accept her decision and take no further action
- ✓ D. Explain that you will always respect her decision but ask her to come and see you in one week
- E. Explain to the patient that given her decision you are obliged to seek psychiatric review under GMC guidelines

Next question

This scenario looks at autonomy in a competent adult. Whilst her decision may seem illogical to you this is not grounds for presuming a lack of mental capacity. The best course of action if to respect her decision but arrange follow-up after she has had time to think.

As mentioned previously an illogical decision is not grounds for presumption of mental incapacity. A psychiatric review is therefore inappropriate and is likely to alienate the patient.

Calling her daughter breaks confidentiality and is the worst option.

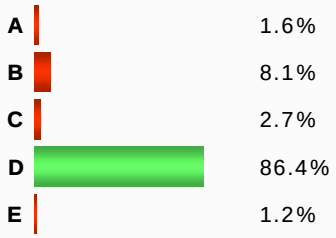
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Rate question:

Next question

Comment on this question

Question stats



86.4% of users answered this question correctly

Session score = 25%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

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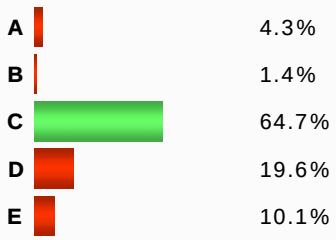
Question 17 of 93

A 62-year-old woman presents after being discharged from hospital. She was diagnosed as having ovarian cancer six weeks ago and following surgery she is awaiting chemotherapy. Her main reason for coming was to ask for a sick note. What is the maximum length of time you may issue the Statement of Fitness for Work for?

- A. 1 month
- B. 2 months
- ✓ C. 3 months
- D. 6 months
- E. Indefinitely

Next question

Question stats



64.7% of users answered this question correctly

Session score = 29.4%

Statement of Fitness for Work

In 2010 sick notes became fit notes, or more formally the Statement of Fitness for Work. They have been introduced to reflect the fact that in the majority of cases patients do not need to be 100% fit before returning to work. The major change is allowing a doctor to advise that a patient 'may be fit for work taking account of the following advice'.

This information is taken from the Department of Work and Pensions website. Please see the link for further details.

Other changes

- the Statement of Fitness for Work replaces the Med3 and Med5 in one form
- the Med4, Med6 and RM 7 forms have been withdrawn due to the replacement of Incapacity Benefit with the Employment and Support Allowance
- telephone consultations are now an acceptable form of assessment
- there is no longer a box to say a patient is fit for work. There is however an option to state if you need to assess your patient's fitness for work again at the end of the statement period
- there is increased space for comments on the functional effects of the condition, including tick boxes for simple things that may help a patient back to work
- during the first 6 months of an illness the new statement can be issued for no longer than 3 months.. After this time it may be issued for an indefinite period

Things that stay the same

- can only be completed by a doctor
- you can still the advise a patient that they are not fit for work (of any type)
- the advice on the statement is not binding on employers

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

External links

Department of Work and Pensions
Statement of Fitness for Work

The statement may be issued:

- on the day that you assessed the patient
- on a date after you assessed your patient if you consider that it would have been reasonable to issue a statement on the day of the assessment
- after consideration of a written report from another doctor or registered health care professional

There are 4 'tick boxes' included on the form which represent common approaches to aid a return to work. One or more may be ticked. Other approaches can be suggested in the comments box. The options are:

- a phased return to work
- altered hours
- amended duties
- workplace adaptations

Patients may self-certify for the first 7 calendar days:

SC1	Self-certification, for patients not eligible to claim statutory sick pay (e.g. Unemployed or self-employed). For the first 7 calendar days of an illness
SC2	The 'standard' self-certification form, for patients eligible to claim statutory sick pay. For the first 7 calendar days of an illness

Rate question:

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Question 19 of 93

Which one of the following situations would not automatically require a doctor to contact the coroner to discuss the death?

- A. 54-year-old woman dies 14 hours after admission to hospital with metastatic breast cancer
- B. 71-year-old man dies during an emergency abdominal aortic aneurysm repair
- ✓ C. 38-year-old with alcoholic liver disease dies after 2 week admission to hospital with liver failure
- D. 72-year-old with a history of asbestos related pleural plaques dies of colorectal cancer in a hospice
- E. 24-year-old dies following a road traffic accident

Next question

Even though the 72-year-old patient in stem D died of colorectal cancer he still needs to be reported to the coroner as he has a history of asbestosis

Death certification: notifiable deaths

The following deaths should be reported to the coroner

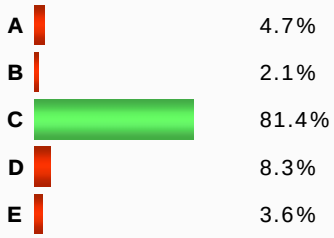
- unexpected or sudden deaths
- when the doctor attending the deceased did not see them within 14 days before death
- if a death occurs within 24 hours of hospital admission
- accidents and injuries
- suicide
- industrial injury or disease (e.g. asbestosis)
- deaths occurring as a result of ill treatment, starvation or neglect
- the death occurred during an operation or before recovery from the effect of an anaesthetic
- poisoning, including taking illicit drugs
- stillbirths - if there is doubt as to whether the child was born alive
- prisoner or people in police custody
- service disability pensioners

Rate question:

Next question

Comment on this question

Question stats



81.4% of users answered this question correctly

Session score = 36.8%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

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Questions 20 to 22 of 93

Theme: DVLA: neurological disorders

A No restriction
B No restriction but inform DVLA
C 1 month off
D 3 months off
E 6 months off
F 12 months off
G Once satisfactory control of symptoms
H Cannot drive

For each of the following scenarios select the most appropriate advice regarding driving:

20. Transient ischaemic attack - multiple episodes over short period

1 month off

The correct answer is 3 months off

21. Narcolepsy

Cannot drive

The correct answer is Once satisfactory control of symptoms

22. Simple faint

No restriction

Next question

Question stats

Average score for registered users:

20	62.3%
21	70.9%
22	94.8%

Session score = 36.4%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

External links

DVLA
Neurological disorder guidelines

DVLA: neurological disorders

The guidelines below relate to car/motorcycle use unless specifically stated. For obvious reasons, the rules relating to drivers of heavy goods vehicles tend to be much stricter

Specific rules

- first seizure: 6 months off driving*. For patients with established epilepsy they must be fit free for 12 months before being able to drive
- stroke or TIA: 1 month off driving
- multiple TIAs over short period of times: 3 months off driving
- craniotomy e.g. For meningioma: 1 year off driving**
- pituitary tumour: craniotomy: 6 months; trans-sphenoidal surgery 'can drive when there is no debarring residual impairment likely to affect safe driving'
- narcolepsy/cataplexy: cease driving on diagnosis, can restart once 'satisfactory control of symptoms'

Syncope

- simple faint: no restriction
- unexplained, low risk of recurrence: 4 weeks off
- explained and treated: 4 weeks off
- unexplained: 6 months off

*previously rule was 12 months. It is now 6 months off driving if the licence holder has undergone assessment by an appropriate specialist and no relevant abnormality has been identified on investigation, for example EEG and brain scan where indicated

**if the tumour is a benign meningioma and there is no seizure history, licence can be reconsidered 6 months after surgery if remains seizure free

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Question 23 of 93

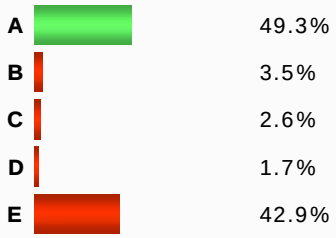
You are asked to complete the Cremation 5 form of a patient from a neighbouring practice who has recently died. The patient was a 78-year-old man with metastatic lung cancer. Which one of the following best describes your responsibilities?

- A. View the body + discuss with patient's GP
- B. View the body + discuss with family
- C. View the body + contact coroner's office
- D. View the body
- E. View the body + brief review of case notes + discuss with patient's GP

Next question

Cremation form - Cremation 5 responsibilities: view the body + discuss with patient's GP

Question stats



49.3% of users answered this question correctly

Session score = 34.8%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

Cremation forms

Basics

- the Ministry of Justice have issued new cremation regulations which came into effect on 1st January 2009
- there is a new right of inspection of medical forms to the applicant of cremation
- 2 doctors are required to confirm both the identity and that the cause of death was not suspicious
- form B is replaced by **Cremation 4**. This should be completed by the patient's own GP or a doctor looking after them during their last illness e.g. Hospital doctors
- form C is replaced by **Cremation 5**. This should be completed by an independent doctor who must have held a full GMC registration for more than 5 years. The doctor is expected to discuss the case with the patient's GP and view the body
- the form Cremation 5 doctor cannot be a partner or work colleague of the form Cremation 4 doctor or a relative of the deceased; the two doctors must be independent of one another, i.e. Not on the same team in hospital or at the same GP surgery
- a fee is payable to each doctor

Rate question:

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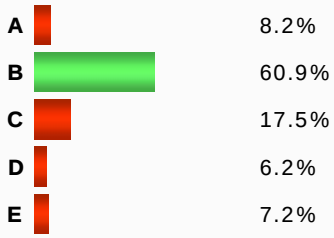
Question 24 of 93

Which one of the following is not a reason to exception report a patient under the quality and outcomes framework (QOF)?

- A. Where a patient has not tolerated a medication
- ✓ B. Patients with a chronic disease who are predominately managed in secondary care
- C. Where a secondary care service is unavailable
- D. Patients with a chronic disease who are terminally ill
- E. Patients who are on maximum tolerated doses of medication whose treatment remain sub-optimal

Next question

Question stats



60.9% of users answered this question correctly

Session score = 33.3%

Quality and Outcomes Framework

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

The Quality and Outcomes Framework (QOF) is the annual reward and incentive programme detailing GP practice achievement results. It was introduced as part of the new General Medical Services (GMS) to incentivise not only the management of chronic disease such as diabetes but also to improve the organisation of the practice and patient experience

Other points

- for clinical indicators the value of a point is determined by the prevalence of that condition in the practice
- participation in the QOF is voluntary
- 5% of practices should be visited at random to help prevent fraud. The PCT visiting team will normally consist of a PCT management representative, a GP and a patient representative

The table below shows the four key areas on which the QOF is based

Clinical indicators	697 points	Standards linked to the care of patients suffering from chronic diseases
Organisational	167.5 points	Standards relating to records and information, communicating with patients, education and training, medicines management and clinical and practice management
Additional services	44 points	Covering cervical screening, child health surveillance, maternity services and contraceptive services
Patient experience	91.5 points	Based on patient surveys and length of consultations

Patients may be 'exception reported' in the following situations:

- patients who have been recorded as refusing to attend review who have been invited on at least three occasions during the preceding 12 months
- patients for whom it is not appropriate to review the chronic disease parameters due to particular circumstances e.g. Terminal illness, extreme frailty
- patients newly diagnosed within the practice or who have recently registered with the practice, who should have measurements made within 3 months and delivery of clinical standards within 9 months e.g. Blood pressure or cholesterol measurements within target levels
- patients who are on maximum tolerated doses of medication whose treatment remain sub-optimal
- patients for whom prescribing a medication is not clinically appropriate e.g. Those who have an allergy, another contraindication or have experienced an adverse reaction
- where a patient has not tolerated medication
- where a patient does not agree to investigation or treatment (informed dissent), and this has been recorded in their medical records
- where the patient has a supervening condition which makes treatment of their condition inappropriate e.g. Cholesterol reduction where the patient has liver disease
- where an investigative service or secondary care service is unavailable

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Question 25 of 93

A 69-year-old woman with rheumatoid arthritis presents for review. She has severe disease of her hands and requires help with washing and dressing. Which one of the following benefit forms should be completed?

- A. Attendance Allowance
- B. Incapacity Benefit
- C. Disability Living Allowance
- D. SF300
- E. DS1500

Next question

As this patient is greater than 65-years-old she is entitled to Attendance Allowance rather than Disability Living Allowance

Benefits: chronic illness and cancer patients

Patients who have a chronic illness or cancer, which results in a disability severe enough to need help with caring for themselves, are entitled to claim the following benefits:

- Disability Living Allowance: for patients under the age of 65 years
- Attendance Allowance: for patients over aged 65 years and over

Disability Living Allowance

Disability Living Allowance (DLA) can be claimed by patients who normally have needed help for at least 3 months and be likely to need it for at least a further 6 months. It is tax-free, not means tested and divided into two components:

- Care component
- Mobility component

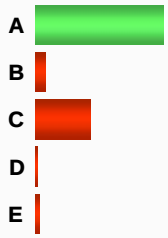
Attendance Allowance

Attendance Allowance (AA) is a tax-free allowance for people aged 65 or over when they claim who need help with their personal care. To claim AA patients should normally have needed help with care for 6 months. Like DLA it is not means tested

Terminally ill patients

Patients who have a terminal illness (where there is an expectation that the patient will not live for more than 6 months) are eligible to be fast-tracked through the system for claiming DLA or AA. A **DS1500** form is completed which ensures the application is dealt with promptly and that the patient automatically receives the higher rate

Question stats



64.7% of users answered this question correctly

Session score = 32%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

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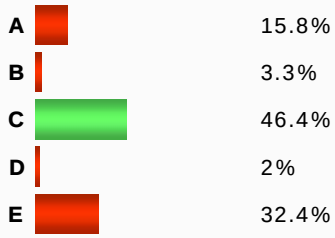
Question 26 of 93

Which one of the following best describes the proposed objective of Secondary Uses Service (SUS) as part of the NHS Connecting for Health plan?

- A. Generates electronic prescriptions to be used by pharmacists
- B. Allows patients to have limited access to their own records over the internet
- ✓ C. Generates anonymised data for research and planning purposes
- D. Allows commercial companies to have limited access to patient records
- E. Allows hospital doctors to view primary care records

Next question

Question stats



46.4% of users answered this question correctly

Session score = 30.8%

Information management and technology

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

Information management and technology is one of the key parts of the RCGP curriculum

Clinical coding systems

- Read codes: used to code almost any aspect of medical care including symptoms, examinations, investigations, administration, diagnoses and treatment
- SNOMED CT (Systematized Nomenclature of Medicine -- Clinical Terms) is a new system which is replacing Read codes. It will be used by NHS Connecting For Health as the standard terminology for the NHS Care Records Service

Connecting for health

- the NHS Care Records Service (NHS CRS) will be connected by what is known as 'the spine'
- a key part of the NHS CRS will be the gradual development of an electronic Summary Care Record
- Choose and Book will allow GPs and other primary care staff to make initial hospital or clinic outpatient appointments using the spine
- provide a Secondary Uses Service (SUS), using anonymised data for business reports and statistics for research and planning purposes
- Electronic Prescription Service (EPS) is being planned meaning GPs will prescribe a drug electronically after which pharmacists will be able to dispense without a written prescription

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Question 27 of 93

How are Local Medical Committees funded?

- A. Voluntary donations by GPs and Practices
- ✓ B. Statutory levy on GPs
- C. Primary Care Trust
- D. Department of Health
- E. Fundraising activities such as the Christmas Ball

Next question

Question stats

A	5.4%
B	53.3%
C	31.6%
D	9.4%
E	0.3%

53.3% of users answered this question correctly

Session score = 29.6%

Local Medical Committees

Local Medical Committees (LMCs) represent the interests of GPs on a local level. They were established as part of Lloyd George's National Insurance Act in 1911 to try and ensure that GPs had a say in the running of the government's health insurance scheme. At the same time a committee was established within the British Medical Association (BMA) to represent GPs on a national level to the government. This was initially known as the Insurance Acts Committee but is now called the General Practitioners Committee (GPC) and has authority to negotiate with the government on matters such as pay and contracts. It is recognised by the Department of Health as the GP's sole negotiating body.

The GPC meets annually with the representatives of the LMCs, who may submit motions for the conference. This motions may then go on to form GPC policy.

LMCs are funded by a statutory levy on GPs. Each LMC may cover the area which corresponds to one or more Primary Care Trusts. LMC members are elected and include partners, salaried doctors and GP Registrars from both GMS and PMS practices .

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

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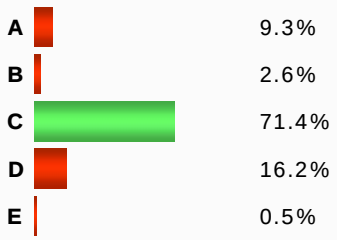
Question 28 of 93

A 34-year-old heroin addict starts methadone treatment. What is the correct procedure with regards to notification?

- A. Notify Primary Care Trust if patient consent obtained
- B. Notify Primary Care Trust without informing patient
- C. Notify National Drug Treatment Monitoring System if patient consent obtained
- D. Notify National Drug Treatment Monitoring System without informing patient
- E. Notify the local Police Department if patient consent obtained

Next question

Question stats



71.4% of users answered this question correctly

Session score = 28.6%

Notification of drug misusers

Doctors should inform their regional or national drug misuse centre of patients who have problems with drug misuse including opioid, benzodiazepines and CNS stimulants. Contact details may be found in the BNF. The National Drug Treatment Monitoring System (NDTMS) collects data which allows the planning of drug services and allows the evaluation of the efficiency and effectiveness of drug treatment provision.

Consent needs to be obtained prior to sending patient data to the NDTMS.

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

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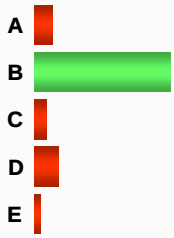
Question 29 of 93

A 44-year-old man dies at home of a HIV-related illness. His next-of-kin was his mother who was not aware of his HIV infection. He had asked the doctors who had treated him not to disclose this to his family. When completing the cremation form what is the most appropriate action?

- A. Do not disclose HIV infection on cremation form but only list contributory illnesses e.g. Pneumocystis pneumonia
- ✓ B. Do not disclose HIV infection on cremation form but provide a confidential report to the medical referee on a separate piece of paper
- C. Record his illness as a 'CD4 disorder'
- ✗ D. Disclose HIV infection
- E. Advise his family not to view the cremation forms

Next question

Question stats



68.9% of users answered this question correctly

Session score = 27.6%

Patient confidentiality should be maintained if possible, even following the death of a patient.

The family now has a right to view both cremation forms. In difficult situations like this it would be advisable to speak to the coroner.

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

Cremation forms

Basics

- the Ministry of Justice have issued new cremation regulations which came into effect on 1st January 2009
- there is a new right of inspection of medical forms to the applicant of cremation
- 2 doctors are required to confirm both the identity and that the cause of death was not suspicious
- form B is replaced by **Cremation 4**. This should be completed by the patient's own GP or a doctor looking after them during their last illness e.g. Hospital doctors
- form C is replaced by **Cremation 5**. This should be completed by an independent doctor who must have held a full GMC registration for more than 5 years. The doctor is expected to discuss the case with the patient's GP and view the body
- the form Cremation 5 doctor cannot be a partner or work colleague of the form Cremation 4 doctor or a relative of the deceased; the two doctors must be independent of one another, i.e. Not on the same team in hospital or at the same GP surgery
- a fee is payable to each doctor

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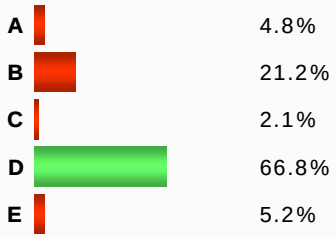
Question 30 of 93

You are organising a review of the management of controlled drug prescription in the surgery. Which one of the following is a Schedule 2 controlled drug as defined by the 2001 Misuse of Drugs Regulations act?

- A. Cannabis
- B. Midazolam
- C. Anabolic steroids
- ✓ D. Diamorphine
- E. Buprenorphine

Next question

Question stats



66.8% of users answered this question correctly

Session score = 26.7%

Controlled drugs

When prescribing a controlled drug the following must be present on the prescription:

- name and address of the patient
- the form, and where appropriate the strength, of the preparation

- either the total quantity (in both words and figures) of the preparation, or the number (in both words and figures) of dosage units to be supplied

- the dose (cannot write 'as directed')
- prescribers name, signature, address and current date

The 2001 Misuse of Drugs Regulations act defines who is authorised to prescribe controlled drugs. It divided drugs of potential abuse into 5 categories ('schedules') each with own rules on prescribing, supply, possession, record keeping etc

Schedule 1	Cannabis, lysergide
Schedule 2	Diamorphine, morphine, pethidine, amphetamine, cocaine
Schedule 3	Barbiturates, buprenorphine, midazolam*, temazepam**
Schedule 4	**Part 1**: Benzodiazepines (except midazolam and temazepam) and zolpidem **Part 2**: Androgenic and anabolic steroids, hCG, somatropin Controlled drug prescription requirements do not apply and Schedule 4 controlled drugs are not subject to safe custody requirements
Schedule 5	Includes preparations which because of their strength are exempt from the vast majority of Controlled Drug requirements other than retention of

RCGP curriculum

3.2 - Patient Safety

Curriculum statement

External links

UK Government
Misuse of Drugs Regulations 2001

	invoices (e.g. Oramorph 10mg/5ml)

Further selected points

- Schedule 2 and 3 drugs are marked 'CD' in the BNF
- a prescription for controlled drugs in Schedules 2,3 & 4 is valid for 28 days
- a pharmacist is generally not allowed to dispense unless all the information required by law is given. With Schedule 2 and 3 drugs a pharmacist is allowed to amend the prescription if 'it specifies the total quantity only in words or in figures or if it contains minor typographical errors, provided that such amendments are indelible and clearly attributable to the pharmacist making them'

*midazolam was changed from schedule 4 to 3 in 2008

**temazepam is excluded from the prescription requirements

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Questions 31 to 33 of 93

Theme: Consultation models

A Heron
B Kurtz and Silverman
C Berne
D Fraser
E Neighbour
F Balint
G Stott and Davis
H Helman's folk model
I Pendleton

For each of the following tasks select the consultation model most associated with it

31. Define the reason for the patient's attendance

Pendleton

32. Use time and resources appropriately

Heron

The correct answer is Pendleton

33. Opportunistic health promotion

Heron

The correct answer is Stott and Davis

Next question

Question stats

Average score for registered users:

31	52.5%
32	47.2%
33	60.7%

Session score = 27.3%

RCGP curriculum

2 - The General Practice Consultation

Curriculum statement

Consultation models

Calgary-Cambridge observation guide- Kurtz and Silverman - 1996

- initiating the session
- gathering information
- building the relationship

- giving information, explaining and planning
- closing the session

Stewart - patient-centred clinical method - 1995. 2003

- exploring both the disease and the illness experience
- understanding the whole person
- finding common ground
- incorporating prevention and health promotion
- enhancing the doctor-patient relationship
- being realistic (with time and resources)

Pendleton - The Consultation: an Approach to Learning and Teaching - 1984, 2003

- define the reason for the patient's attendance (ideas, concerns and expectations)
- consider other problems
- with the patient, choose an appropriate action for each problem
- achieve a shared understanding of the problems with the patient
- involve the patient in the management and encourage him/her to accept appropriate responsibility
- use time and resources appropriately
- establish or maintain a relationship with the patient which helps to achieve the other tasks

Fraser - Areas of competence - 1992

- interviewing and history-taking
- physical examination
- diagnosis and problem-solving
- patient management
- relating to patients
- anticipatory care
- record keeping

Neighbour - The Inner Consultation - five checkpoint model - 1987

- connecting
- summarising
- handing over
- safety netting
- housekeeping

Tuckett - meeting of two experts - 1985

- the consultation is a meeting between two experts
- doctors are experts in medicine
- patients are experts in their own illnesses
- shared understanding is the aim
- doctors should seek to understand the patient's beliefs
- doctors should address explanations in terms of the patient's belief system

Stott and Davis - Exceptional potential of the consultation - 1979

- management of presenting problems
- management of continuing problems
- modification of help-seeking behaviour
- opportunistic health promotion

Rate question:

Next question

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Question 34 of 93

You see a 29-year-old man with asthma. He tells you he has come to see you today because one of the partners refuses to alter his inhaler therapy until he gives up smoking. He is currently using a salbutamol inhaler as required but is now having frequent episodes of wheeze and he has developed a nocturnal cough. What is the most appropriate action?

- A. Remove him from the practice list if he refuses to give up smoking
- B. Alter his inhaler treatment and raise it at the practice meeting
- ✓ C. Alter his inhaler treatment and speak to the doctor concerned
- D. Refuse to alter his inhaler treatment until he has agreed to be referred to smoking cessation
- E. Alter his inhaler treatment and advise the patient to see you next time

Next question

Although continuing to smoke is clearly going to make his asthma control worse it is not a reason to withhold treatment from a patient. After being made aware of this you have duty to follow it up with the doctor concerned. This also allows the doctor to explain the consultation from his/her point of view. Raising this at the practice meeting is less ideal as it may appear confrontational.

Altering his inhaler treatment alone fails to address the issue of treatment being withheld. Refusing to alter his inhalers until he has agreed to be referred to smoking cessation is basically blackmail and not acceptable. Removing him from the practice list for not giving up smoking again is clearly wrong.

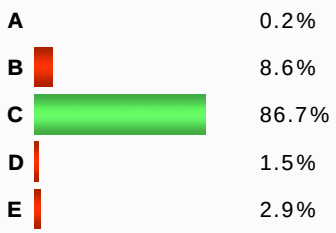
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Rate question:

Next question

Comment on this question

Question stats



86.7% of users answered this question correctly

Session score = 29.4%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

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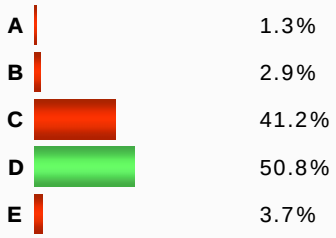
Question 35 of 93

Which one of the following statements regarding the Yellow Card scheme is correct?

- A. Each Yellow Card requires two doctors to confirm the adverse event
- B. Online reporting is currently limited to vaccines
- C. All adverse events should be reported, even for established drugs
- D. Patients can complete Yellow Cards
- E. Only confirmed adverse events should be reported

Next question

Question stats



50.8% of users answered this question correctly

Session score = 28.6%

Yellow Card scheme

The Yellow Card scheme has become the standard way to report adverse reactions to medications. It is run by the Medicines and Healthcare products Regulatory Agency (MHRA).

The following should be reported (taken from the MHRA website)

- all suspected adverse drug reactions for new medicines (identified by the black triangle symbol) should be reported
- all suspected adverse drug reactions occurring in children, even if a medicine

has been used off-label

- all serious* suspected adverse drug reactions for established vaccines and

medicines, including unlicensed medicines, herbal remedies, and medicines used off-label

Other information

- Yellow Cards are found at the back of the BNF or reports can be completed online (www.yellowcard.gov.uk)
- any suspected reactions (not just confirmed) should be reported
- patients can report adverse events
- Yellow Cards are sent to the MHRA who in collate and assess the information. In turn the MHRA may consult with the Commission on Human Medicines (CHM), an independent scientific advisory body on medicines safety

*reactions which are fatal, life-threatening, disabling or incapacitating, result in or prolong hospitalisation, or medically significant are considered serious.

RCGP curriculum

3.2 - Patient Safety

Curriculum statement

External links

MHRA
Yellow Card scheme

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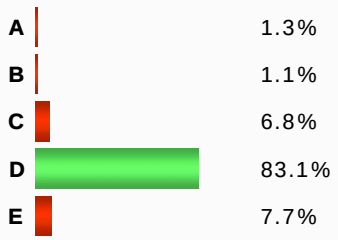
Question 36 of 93

A 49-year-old man with motor neuron disease asks for advice. He has read about the Mental Capacity Act and after discussion with his wife has decided he does not want to be ventilated in the event of respiratory failure. What is the most appropriate action to take?

- A. Advise that it is not possible to make orders relating to life-sustaining treatment
- B. Refer to psychiatrist for formal assessment of capacity
- C. Advise him to make his wife the lasting power of attorney
- ✓ D. Advise that his wishes should be written, signed and witnessed
- ✗ E. Make a record in the clinical notes

Next question

Question stats



83.1% of users answered this question correctly

Session score = 27.8%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

It is preferable that the patient makes a formal advance directive. Lasting power of attorney arrangements exclude decisions about life-sustaining treatments unless specifically mentioned

Mental Capacity Act

The Mental Capacity Act of 2005 came into force in 2007. It applies to adults over the age of 16 and sets out who can take decisions if a patient becomes incapacitated (e.g. following a stroke). Mental capacity includes the ability to make decisions affecting daily life, healthcare and financial issues.

The Act contains 5 key principles:

- A person must be assumed to have capacity unless it is established that he lacks capacity
- A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success
- A person is not to be treated as unable to make a decision merely because he makes an unwise decision
- An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests
- Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action

Assessment of capacity

The Act sets out a clear test for assessing whether a person lacks capacity. It is a 'decision-specific' and 'time-specific' test. An adult can only be considered unable to make a particular decision if:

1. He or she has an 'impairment of, or disturbance in, the functioning of the mind or
brain' whether permanent or temporary AND

2. He or she is unable to undertake any of the following

- a. understand the information relevant to the decision
- b. retain that information
- c. use or weigh that information as part of the process of making the decision
- d. communicate the decision made by talking, sign language or other means

No individual can be labelled ‘incapable’ simply as a result of a particular medical condition. Section 2 of the Act makes it clear that a lack of capacity cannot be assumed by a person’s age, appearance, or any condition or aspect of a person’s behaviour

Best interests

The following should be considered when assessing what is in someone’s best interests:

- 1. Whether the person is likely to regain capacity and can the decision wait.
- 2. How to encourage and optimise the participation of the person in the decision.
- 3. The past and present wishes, feelings, beliefs, values of the person and any other relevant factors
- 4. Views of other relevant people

Lasting Powers of Attorney (LPAs)

The Act allows a person to appoint an attorney to act on their behalf if they should lose capacity in the future, replacing the current Enduring Power of Attorney (EPA). In addition to property and financial affairs the Act also allows people to empower an attorney make health and welfare decisions. The attorney only has the authority to make decisions about life-sustaining treatment if the LPA specifies that. Before it can be used an LPA must be registered with the Office of the Public Guardian

Advance decisions

Advance decisions can be drawn up by anybody with capacity to specify treatments they would not want if they lost capacity. They may be made verbally unless they specify refusing life-sustaining treatment (e.g. Ventilation) in which case they need to be written, signed and witnessed to be valid. Advance decisions cannot demand treatment

Rate question:

Next question

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Question 37 of 93

You are a GP registrar. It is Saturday morning and your neighbour asks you to have a look at their 4-year-old son. They think he may an ear infection and wonder if he needs antibiotics. How should you respond?

- A. Assess the child and prescribe if appropriate to avoid unnecessary use of NHS resources
- B. Tell her it is inappropriate to ask a friend to see her son and suggest she takes him to A&E if she is worried
- C. Explain that unfortunately it is not good practice to treat family or friends and suggest they take their son to the out-of hours service
- D. Assess the child to make sure he is not acutely unwell but don't prescribe
- E. Give him a 'delayed-prescription' to use if the child doesn't pick in the next 48 hours

Next question

Question stats

A	1.4%
B	1.2%
C	68.2%
D	28.7%
E	0.4%

68.2% of users answered this question correctly

Session score = 27%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

It is bad practice to assess or treat family members of friends where this is avoidable. One of the primary reasons is that it may affect your clinical judgement. The most appropriate advice is to ask the neighbour to take his child to the out-of-hours service if they are concerned. This is a better response than telling the patient off and directing them to A&E. Firstly non-medics may not be aware of our professional guidance. If you lived next door to a plumber you may feel it reasonable for him to help if your pipes burst! Also, A&E is not the most appropriate place to send a child with a suspected ear infection.

Assessing the child is a poor response for the reasons given above. Giving a prescription without even assessing the child is a very poor option for many obvious reasons e.g. failure to exclude a serious illness, lack of knowledge of his past medical history and allergies etc.

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Rate question:

Next question

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Question 38 of 93

How long should a patient stop driving for following an elective cardiac angioplasty?

- A. No restriction
- B. 1 week ✓
- C. 2 weeks
- D. 4 weeks ✗
- E. 8 weeks

Next question

DVLA advice following angioplasty - cannot drive for 1 week

Question stats

A	3.7%
B	79.1%
C	6.1%
D	11%
E	0.2%

79.1% of users answered this question correctly

Session score = 26.3%

DVLA: cardiovascular disorders

The guidelines below relate to car/motorcycle use unless specifically stated. For obvious reasons, the rules relating to drivers of heavy goods vehicles tend to be much stricter

Specific rules

- angioplasty (elective) - 1 week off driving
- CABG - 4 weeks off driving
- acute coronary syndrome- 4 weeks off driving, 1 week if successfully treated by angioplasty
- angina - driving must cease if symptoms occur at rest/at the wheel
- pacemaker insertion - 1 week off driving
- implantable cardioverter-defibrillator: if implanted for sustained ventricular arrhythmia: cease driving for 6 months. If implanted prophylatically then cease driving for 1 month
- successful catheter ablation for an arrhythmia- 2 days off driving
- aortic aneurysm of 6cm or more - notify DVLA. Licensing will be permitted subject to annual review. An aortic diameter of 6.5 cm or more disqualifies patients from driving
- heart transplant: DVLA do not need to be notified

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

External links

DVLA
Cardiovascular disorder guidelines

Rate question:

Next question

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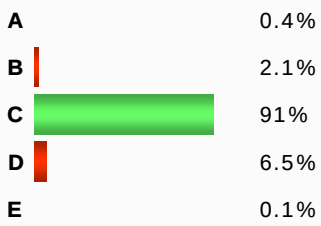
Question 39 of 93

You are a ST1 doctor working at the local genitourinary medicine clinic. A 16-year-old female patient is found to have *Chlamydia*. When she is called back in she refuses to give details of her previous or current partner. What is the most appropriate action?

- A. Refuse to treat her + contact her parents to help persuade her
- B. Give her a tablet of azithromycin to give to her partner
- ✓ C. Treat her and explore the reasons why she does not want to tell her previous or current partner
- ✗ D. Treat her but tell her she risk infertility through re-infection if her partner is not treated
- E. Refuse to treat her if she doesn't give you any details

Next question

Question stats



91% of users answered this question correctly

Session score = 25.6%

The scenario looks at confidentiality and empathy.

A key concept here is to treat her regardless of whether she 'cooperates' and gives you the names of her previous partners. Refusing to treat her is blackmail and clearly unacceptable, as is breaking confidentiality and telling her parents.

The best response is to explore why she doesn't want to tell her previous or current partners. This may lead to a discussion where you are able to allay her fears. The second approach, whilst likely to represent a factual statement, is less likely to get to the bottom of the problem.

Giving her a tablet of azithromycin to give her partner is the worst option.

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

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Next question

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Question 40 of 93

Plans for revalidation are currently being drawn up by the RCGP. How many learning credits will be required each year?

- A. 20
- ✓ B. 50
- C. 100
- D. 200
- E. 250

Next question

Question stats

A	6.3%
B	74%
C	11.4%
D	6.1%
E	2.2%

74% of users answered this question correctly

Session score = 25%

Revalidation

RCGP curriculum

3.1 - Clinical Governance

Curriculum statement

External links

RCGP
Revalidation

Revalidation introduces a change in the way doctors are licensed and certificated. Currently UK doctors automatically receive their licence to practise if they have paid their annual fee and have no limitations on their registration (e.g. Following a GMC ruling). To practise as a GP doctors must also be on the GP Register - a process known as certification.

Following the introduction of revalidation doctors will be required to prove their fitness to practise to allow them to continue to work as a doctor. Revalidation will occur every 5 years and in one process combine relicensing and recertification. Annual appraisals will continue as before but there will be a focus on whether the doctor is making sufficient progress towards their revalidation portfolio.

The type and amount of evidence required will be similar to that needed for appraisals currently. The RCGP is creating an ePortfolio for the process and proposes that it should contain the following (please see the link for more details):

- description of your work
- description of any special circumstances (e.g. Prolonged illness)
- details of previous appraisals
- current personal development plan
- review of previous personal development plans
- evidence of continuing professional development - at least 50 'learning credits' are required per year
- multi-source feedback
- patient questionnaire surveys
- significant event audits
- review of any formal complaints
- probity/health statements

Learning credits

- minimum of 1 credit for each hour of education
- however, if the hour of education can be shown to lead to improvements in

patient care then it will count as 2 credits

Submitting the evidence for revalidation

- the ePortfolio will be submitted electronically for review
- the review will be done by a 'Responsible Officer'
- the Responsible Officer is likely to be advised by a GP assessor and a trained lay person
- if the submitted evidence is considered sufficient the Responsible Officer will recommend to the GMC that the doctor is both relicensed and recertificated

Revalidation is due to be phased in from 2011 to 2016.

Rate question:

Next question

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Question 41 of 93

A 53-year-old heavy goods vehicle driver with a history of type II diabetes mellitus is reviewed in the diabetes clinic. Despite maximal oral hypoglycaemic therapy his HbA1c is 9.7%. If insulin therapy is started then which one of the following is most appropriate with regards to his job?

- A. Cannot continue to drive heavy goods vehicle
- B. Inform DVLA and recommence driving once stable insulin dose achieved
- C. Can only drive during daylight hours
- D. As under 55 years of age then no requirement to inform DVLA
- E. Needs annual screening to exclude retinopathy or neuropathy

Next question

Patients on insulin cannot hold a HGV licence

The April 2009 AKT feedback report made specific mention of fitness to drive rules.

DVLA: diabetes mellitus

The guidelines below relate to car/motorcycle use unless specifically stated. For obvious reasons, the rules relating to drivers of heavy goods vehicles (HGVs) tend to be much stricter

Specific rules

- if on insulin then cannot hold HGV licence*
- if on insulin then patient can drive a car as long as they have hypoglycaemic awareness and no relevant visual impairment
- if on tablets, exenatide or gliptin no need to notify DVLA
- if diet controlled alone and no relevant complications (e.g. Maculopathy) then no requirement to inform DVLA

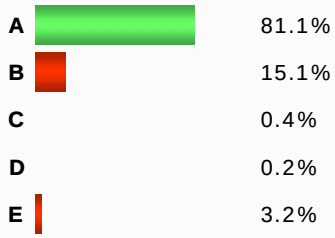
*there are complex exceptions to this rule, but these are not relevant for the purposes of the exam

Rate question:

Next question

Comment on this question

Question stats



81.1% of users answered this question correctly

Session score = 24.4%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

External links

DVLA
Diabetes mellitus guidelines

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Questions 42 to 44 of 93

Theme: Evidenced-based recovery times

A Less than 1 week
B 1 - 2 weeks
C 2 - 3 weeks
D 4 - 5 weeks
E 7 weeks
F 9 weeks
G 3 months

For each one of the following procedures select the most appropriate recovery time for a person of working age:

42. Abdominal hysterectomy

Less than 1 week

The correct answer is 7 weeks

43. Laparoscopic inguinal hernia repair

Less than 1 week

The correct answer is 1 - 2 weeks

44. Laparoscopic cholecystectomy

Less than 1 week

The correct answer is 2 - 3 weeks

Next question

Question stats

Average score for registered users:

42	30.1%
43	65.3%
44	36.4%

Session score = 22.7%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

External links

Department of Work and Pensions
Evidenced-based recovery times

Evidenced-based recovery times

The Department for Works and Pensions has produced evidence-based recovery times which certifying medical practitioners should consider when advising patients of working age

Procedure	Recovery time	
	Laparoscopic	Open

Abdominal/groin hernia	1 - 2 weeks	2 - 3 weeks
Appendicectomy	1 - 2 weeks	2 - 3 weeks
Cholecystectomy	2 - 3 weeks	3 - 5 weeks
Hysterectomy	3 weeks (laparoscopic-assisted vaginal)	7 weeks (abdominal)

Rate question:

Next question

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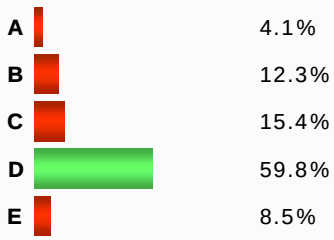
Question 45 of 93

Which one of the following consultation models advocates managing the presenting complaint, managing ongoing health problems and modifying health seeking behaviour?

- A. Neighbour
- B. Fraser
- C. Pendleton
- ✓ D. Stott and Davis
- E. Stewart

Next question

Question stats



59.8% of users answered this question correctly

Session score = 22.2%

Consultation models

Calgary-Cambridge observation guide- Kurtz and Silverman - 1996

- initiating the session
- gathering information
- building the relationship
- giving information, explaining and planning
- closing the session

Stewart - patient-centred clinical method - 1995. 2003

- exploring both the disease and the illness experience
- understanding the whole person
- finding common ground
- incorporating prevention and health promotion
- enhancing the doctor-patient relationship
- being realistic (with time and resources)

Pendleton - The Consultation: an Approach to Learning and Teaching - 1984, 2003

- define the reason for the patient's attendance (ideas, concerns and expectations)
- consider other problems
- with the patient, choose an appropriate action for each problem
- achieve a shared understanding of the problems with the patient
- involve the patient in the management and encourage him/her to accept appropriate responsibility
- use time and resources appropriately
- establish or maintain a relationship with the patient which helps to achieve the other tasks

Fraser - Areas of competence - 1992

RCGP curriculum

2 - The General Practice Consultation

Curriculum statement

- interviewing and history-taking
- physical examination
- diagnosis and problem-solving
- patient management
- relating to patients
- anticipatory care
- record keeping

Neighbour - The Inner Consultation - five checkpoint model - 1987

- connecting
- summarising
- handing over
- safety netting
- housekeeping

Tuckett - meeting of two experts - 1985

- the consultation is a meeting between two experts
- doctors are experts in medicine
- patients are experts in their own illnesses
- shared understanding is the aim
- doctors should seek to understand the patient's beliefs
- doctors should address explanations in terms of the patient's belief system

Stott and Davis - Exceptional potential of the consultation - 1979

- management of presenting problems
- management of continuing problems
- modification of help-seeking behaviour
- opportunistic health promotion

Rate question:

Next question

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Question 46 of 93

After requesting his own medical records a patient attends surgery. He is angry one of your colleagues documented in the notes that 'it is my opinion his ongoing joint symptoms are somatic ?refer psych'. He asks for this entry to be deleted from his records. What is the most appropriate action?

- A. Advise no further action until the patient has seen a rheumatologist
- B. Organise a case conference including a psychiatrist and a representative form the local Patient's Association
- C. Delete the entry + carefully record why it was deleted
- D. Delete any opinion based comments from that earlier entry
- ✓ E. Keep the entry + record the patient's objection

Next question

The previous doctor recorded an accurate entry regarding his clinical impression at the time. Before a definitive diagnosis is reached there is nothing to stop a doctor recording his clinical impression / line-of-thinking. Even if the patient is ultimately diagnosed with an organic problem this does not mean that the original entry was invalid.

This should be explained to the patient but there is no reason to delete this entry.

Data Protection Act

The 1998 Data Protection Act is the main piece of legislation that governs the protection of personal data in the UK. The Act covers both manual and computerised records.

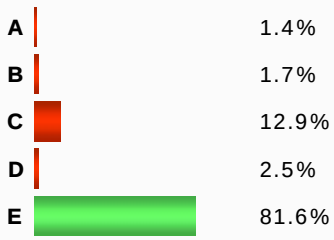
There are 8 main principles of the Data Protection Act:

- data must be used for the specific purpose it was collected
- data must not be disclosed to other parties without the consent of the individual whom it is about
- individuals have a right of access to the information held about them
- personal information may be kept for no longer than is necessary and must be kept up-to-date
- personal information may not be transmitted outside the European Union unless consent has been given
- all entities (e.g. a GP surgery) that process personal information must register with the Information Commissioner's Office
- adequate security measures must be in place. Those include technical measures (e.g. passwords, firewalls) and organisational measures (e.g. staff training)
- subjects (i.e. patients) have the right to have factually incorrect information about them corrected

Rate question:

Next question

Question stats



81.6% of users answered this question correctly

Session score = 21.7%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

External links

Information Commissioner's Office
Guidelines on recording opinions

Comment on this question

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Question 47 of 93

Which one of the following statements regarding the registration and recording of controlled drugs is correct?

- A. The reason for administering the drug must be recorded each time a controlled drug is issued
- B. Must be kept for a minimum of 12 months after the date of the last entry
- C. Schedule 3 drugs must be recorded
- ✓ D. Computerised records are acceptable
- E. The senior partner is responsible for the receipt and supply of CDs from each doctor's bag

Next question

Question stats

A	8.9%
B	15.6%
C	13.4%
D	59.7%
E	2.3%

59.7% of users answered this question correctly

Session score = 21.3%

Controlled drugs: storage and register

Storage

In the surgery controlled drugs (CDs) should be stored in a locked cabinet.

Controlled drugs outside of the surgery must be stored in a locked receptacle (combination lock or key). A doctor's bag with a lock is acceptable. It should be noted that storing a controlled drug in a locked car boot is not acceptable.

Register

A register must be kept for the supply of Schedule 2 drugs.

Specific requirements of the register:

- must be bound rather than loose leaved. Computerised records are acceptable as long as they are secure and auditable
- each drug should have its own individual section
- entries should be chronological and made in indelible ink
- the following information should be recorded when receiving CDs: date, name and address of the supplier, quantity received, name, form and strength
- the following information should be recorded when supplying CDs (either to patients or practitioners): date, name and address of the person receiving the CD, person who prescribed or ordered the CD, quantity supplied, name, form and strength
- must be kept for a minimum of 2 years after the date of the last entry

For doctor's bags a separate CD register should be kept for the CD stock held within that bag. The individual doctor is responsible for the receipt and supply of CDs from their own bag.

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

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Question 48 of 93

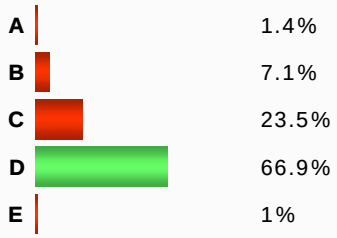
A pregnant woman asks for advice about flying. What is the latest time in her pregnancy that she may fly, presuming an uncomplicated pregnancy with no change in the estimated date of delivery?

- A. 24 weeks
- B. 28 weeks
- C. 32 weeks
- ✓ D. 36 weeks
- E. 38 weeks

Next question

Fitness to fly - pregnancy - up to 36 weeks

Question stats



66.9% of users answered this question correctly

Session score = 20.8%

RCGP curriculum

10.1 - Women's Health

Knowledge

Curriculum statement

External links

Civil Aviation Authority
Fitness to fly guidelines

Fitness to fly

The Civil Aviation Authority (CAA) has issued guidelines on air travel for people with medical conditions; please see the link provided.

Cardiovascular disease

- unstable angina, uncontrolled hypertension, uncontrolled cardiac arrhythmia, decompensated heart failure, severe symptomatic valvular disease: should not fly
- uncomplicated myocardial infarction: may fly after 7-10 days
- complicated myocardial infarction: after 4-6 weeks
- coronary artery bypass graft: after 10-14 days
- percutaneous coronary intervention: after 5 days

Respiratory disease

- pneumonia: should be 'clinically improved with no residual infection'
- pneumothorax: absolute contraindication, the CAA suggest patients may travel 2 weeks after successful drainage if there is no residual air. The British Thoracic Society used to recommend not travelling by air for a period of 6 weeks but this has now been changed to 1 week post check x-ray

Pregnancy

- most airlines do not allow travel after 36 weeks for a single pregnancy and after 32 weeks for a multiple pregnancy
- most airlines require a certificate after 28 weeks confirming that the pregnancy is progressing normally

Surgery

- travel should be avoided for 10 days following abdominal surgery
- laparoscopic surgery: after 24 hours
- colonoscopy: after 24 hours
- following the application of a plaster cast, the majority of airlines restrict flying for 24 hours on flights of less than 2 hours or 48 hours for longer flights

Haematological disorders

- patients with a haemoglobin of greater than 8 g/dl may travel without problems (assuming there is no coexisting condition such as cardiovascular or respiratory disease)

Rate question:

Next question

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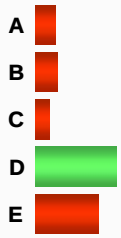
Question 49 of 93

A 72-year-old man presents for review following a recent chest x-ray. The x-ray was ordered due to a slowly resolving chest infection. The x-ray report shows resolution of the infection but notes a small pleural plaque which the report states is likely secondary to asbestos exposure. On discussing the finding he states that he used to work in the boiler room of a ship. What is the most appropriate advice regarding compensation?

- A. He should contact a firm of solicitors and consider suing his former employer for compensation
- B. His family may be eligible for compensation following his death but no other compensation is due
- C. The coroner will decide following his death if compensation is due
- ✓ D. He is not entitled to compensation
- E. He is entitled to an automatic lump-sum payment form the government

Next question

Question stats



40.7% of users answered this question correctly

Session score = 20.4%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

Asbestos and the law

Patients who have developed certain complications following exposure to asbestos are entitled to compensation.

Patients can claim if they develop the following conditions:

- mesothelioma
- asbestosis
- pleural thickening causing disability
- lung cancer caused by asbestos

Under current law patients who have developed pleural plaques are not entitled to compensation.

The coroner should be notified when a patient who had an asbestos-related condition dies.

Rate question:

Next question

Comment on this question

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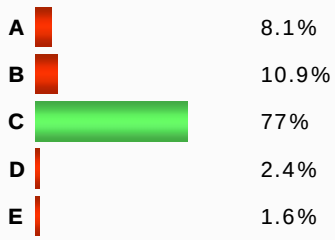
Question 50 of 93

A 34-year-old woman with ulcerative colitis asks for advice about applying for an annual pre-payment certificate. The patient lives in Birmingham. What is the minimum number of prescriptions which she would need to obtain in a year to make it economical?

- A. More than 7
- B. More than 10
- ✓ C. More than 14
- D. More than 22
- E. More than 28

Next question

Question stats



77% of users answered this question correctly

Session score = 20%

Prescription charges

The following information applies to England. Wales has abolished prescription charges and Scotland plans to remove prescription charges altogether by 2011.

Who is entitled to free prescriptions?

- children (< 16 years old)
- aged 16, 17 or 18 and in full-time education
- elderly (aged 60 or over)
- if the patient or their partner receives: income support or jobseeker's allowance
- if the patient has a prescription exemption certificate

Prescription exemption certificate

Women who are pregnant or have had a child in the past year are entitled to free prescriptions after the issuing of a prescription exemption certificate. Patients who have the following chronic medical conditions are also entitled:

- hypoparathyroidism
- hypoadrenalism for which specific substitution therapy is essential (e.g. Addison's Disease)
- diabetes insipidus and other forms of hypopituitarism
- diabetes mellitus except where treatment is by diet alone
- myasthenia gravis
- hypothyroidism requiring thyroid hormone replacement
- epilepsy requiring continuous anti-convulsive therapy
- a permanent fistula requiring continuous surgical dressing or requiring an appliance
- undergoing treatment for cancer. This includes treatment for the effects of cancer or for the effects of cancer treatments

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

Pre-payment certificate

Pre-payment certificates (PPC) are for patients not entitled to free prescriptions but who receive frequent prescriptions. They are cheaper if the patient pays for more than 14 prescriptions per year

Rate question:

Next question

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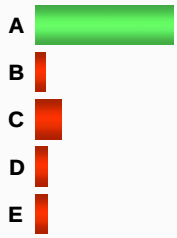
Question 51 of 93

Which one of the following statements regarding Lasting Powers of Attorney, as defined by the 2005 Mental Capacity Act, is incorrect?

- A. Makes decisions on financial but not healthcare or welfare matters ✓
- B. Must be registered with the Office of the Public Guardian
- C. An attorney only has the authority to make decisions about life-sustaining treatment if the LPA specifies that
- D. Replaces the current Enduring Power of Attorney
- E. Allows a person to appoint an attorney to act on their behalf if they should lose capacity in the future

Next question

Question stats



70.1% of users answered this question correctly

Session score = 19.6%

Mental Capacity Act

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

The Mental Capacity Act of 2005 came into force in 2007. It applies to adults over the age of 16 and sets out who can take decisions if a patient becomes incapacitated (e.g. following a stroke). Mental capacity includes the ability to make decisions affecting daily life, healthcare and financial issues.

The Act contains 5 key principles:

- A person must be assumed to have capacity unless it is established that he lacks capacity
- A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success
- A person is not to be treated as unable to make a decision merely because he makes an unwise decision
- An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests
- Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action

Assessment of capacity

The Act sets out a clear test for assessing whether a person lacks capacity. It is a 'decision-specific' and 'time-specific' test. An adult can only be considered unable to make a particular decision if:

1. He or she has an 'impairment of, or disturbance in, the functioning of the mind or
brain' whether permanent or temporary AND

2. He or she is unable to undertake any of the following

- a. understand the information relevant to the decision

- b. retain that information
- c. use or weigh that information as part of the process of making the decision
- d. communicate the decision made by talking, sign language or other means

No individual can be labelled ‘incapable’ simply as a result of a particular medical condition. Section 2 of the Act makes it clear that a lack of capacity cannot be assumed by a person’s age, appearance, or any condition or aspect of a person’s behaviour

Best interests

The following should be considered when assessing what is in someone’s best interests:

- 1. Whether the person is likely to regain capacity and can the decision wait.
- 2. How to encourage and optimise the participation of the person in the decision.
- 3. The past and present wishes, feelings, beliefs, values of the person and any other relevant factors
- 4. Views of other relevant people

Lasting Powers of Attorney (LPAs)

The Act allows a person to appoint an attorney to act on their behalf if they should lose capacity in the future, replacing the current Enduring Power of Attorney (EPA). In addition to property and financial affairs the Act also allows people to empower an attorney make health and welfare decisions. The attorney only has the authority to make decisions about life-sustaining treatment if the LPA specifies that. Before it can be used an LPA must be registered with the Office of the Public Guardian

Advance decisions

Advance decisions can be drawn up by anybody with capacity to specify treatments they would not want if they lost capacity. They may be made verbally unless they specify refusing life-sustaining treatment (e.g. Ventilation) in which case they need to be written, signed and witnessed to be valid. Advance decisions cannot demand treatment

Rate question:

Next question

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Question 52 of 93

Whilst speaking to one of the senior partners at your GP surgery you notice the smell alcohol on his breath. What is the most appropriate course of action?

- A. Explain to him your concerns and ask him if he has been drinking alcohol
- B. Contact your Medical Indemnity Provider for advice
- C. Discuss your concerns with the other partners in the surgery
- D. Call the police
- E. Use the CAGE screening tool to assess whether he is an alcoholic

Next question

Question stats

A	86.5%
B	2.1%
C	11%
D	0.1%
E	0.3%

86.5% of users answered this question correctly

Session score = 19.2%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

The most appropriate response is to directly challenge your colleague about your concerns. As a doctor you have a duty of care to protect patients – a doctor under the influence of alcohol is a potential danger to patients. The next best option is to discuss your concerns with one of the other partners. This would hopefully result in the same action being taken but following a delay.
Phoning your Medical Indemnity Provider is not really necessary as the correct course of action is clear. They would however hopefully advise you on the correct course of action. By using the CAGE screening tool you are starting to act as your colleagues doctor which is not appropriate. If they have a problem with alcohol they need to see their own GP. Although drinking alcohol whilst practising medicine is dangerous and unprofessional is it not a direct matter for the police.

The GMC state the following:
'You should follow the advice in Good Medical Practice in relation to your own health. You should also:
- protect those you manage from risks to their health
- protect patients from risks arising from your own or your colleagues' health
- respond constructively to signs that colleagues have health problems; in particular you
- should be alive to mental health problems, depression, and alcohol and drug dependence
- help and support colleagues who have health problems.'

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Questions 53 to 55 of 93

Theme: Consultation models

A Heron
B Byrne and Long
C Berne
D Fraser
E Neighbour
F Calgary-Cambridge
G Stott and Davis
H Helman's folk model
I Pendleton

For each of the following tasks select the consultation model most associated with it

53. Anticipatory care

Heron

The correct answer is Fraser

54. Modification of help-seeking behaviour

Heron

The correct answer is Stott and Davis

55. Giving information, explaining and planning

Heron

The correct answer is Calgary-Cambridge

Next question

Question stats

Average score for registered users:

53	40.1%
54	61.8%
55	44.5%

Session score = 18.2%

RCGP curriculum

2 - The General Practice Consultation

Curriculum statement

Consultation models

Calgary-Cambridge observation guide- Kurtz and Silverman - 1996

- initiating the session
- gathering information
- building the relationship

- giving information, explaining and planning
- closing the session

Stewart - patient-centred clinical method - 1995. 2003

- exploring both the disease and the illness experience
- understanding the whole person
- finding common ground
- incorporating prevention and health promotion
- enhancing the doctor-patient relationship
- being realistic (with time and resources)

Pendleton - The Consultation: an Approach to Learning and Teaching - 1984, 2003

- define the reason for the patient's attendance (ideas, concerns and expectations)
- consider other problems
- with the patient, choose an appropriate action for each problem
- achieve a shared understanding of the problems with the patient
- involve the patient in the management and encourage him/her to accept appropriate responsibility
- use time and resources appropriately
- establish or maintain a relationship with the patient which helps to achieve the other tasks

Fraser - Areas of competence - 1992

- interviewing and history-taking
- physical examination
- diagnosis and problem-solving
- patient management
- relating to patients
- anticipatory care
- record keeping

Neighbour - The Inner Consultation - five checkpoint model - 1987

- connecting
- summarising
- handing over
- safety netting
- housekeeping

Tuckett - meeting of two experts - 1985

- the consultation is a meeting between two experts
- doctors are experts in medicine
- patients are experts in their own illnesses
- shared understanding is the aim
- doctors should seek to understand the patient's beliefs
- doctors should address explanations in terms of the patient's belief system

Stott and Davis - Exceptional potential of the consultation - 1979

- management of presenting problems
- management of continuing problems
- modification of help-seeking behaviour
- opportunistic health promotion

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Next question

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Question 56 of 93

You are a GP registrar doing a 12 month placement in General Practice. Whilst using one of the partners room for a surgery you notice a half-empty bottle of whisky in the desk drawer. After discussing this with the partner he states that it was a recent gift from a patient and was simply storing it there prior to taking it home. What is the most appropriate course of action?

- A. Document your concerns in an anonymous letter to the practice manager
- ✓ B. Discuss this with one of the other partners in the surgery
- C. Fill in a clinical incident form
- D. Take no further action
- E. Take the bottle from the room and dispose of it

Next question

Question stats

A	1.5%
B	86.2%
C	1.7%
D	10.2%
E	0.4%

86.2% of users answered this question correctly

Session score = 17.9%

In this situation you have already discussed your concerns about alcohol with the doctor but he has denied there is a problem. Of course GPs receive gifts of alcohol frequently and his explanation may be valid. However, given that the bottle is half-empty it is necessary to share your concerns with other doctors in the surgery. They may already be aware of an existing problem and this may provide more 'evidence' for them to take appropriate action. The doctor may also be more willing to admit a problem to a fellow partner rather than a junior colleague such as yourself.

Filling in a clinical incident form will at least formally document your concerns but does not address the problem immediately. Writing an anonymous letter to the practice manager is unprofessional and likely to cause conflict, for example he may suspect one of the other partners wrote the letter.

Removing the bottle does not address the underlying problem. By taking no further action you are potentially exposing patients to ongoing risk – this is clearly the least acceptable option.

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

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Question 57 of 93

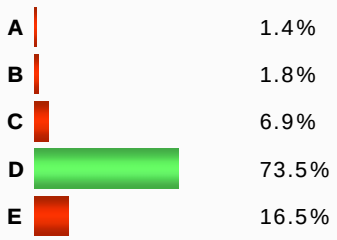
What is the youngest age that allows the term 'Old age' to be written on the death certificate?

- A. 65 years
- B. 70 years
- C. 75 years
- ✓ D. 80 years
- E. 85 years

Next question

Death certification - 'Old age' only after 80 years

Question stats



73.5% of users answered this question correctly

Session score = 19.3%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

External links

Home Office
Guidance for doctors completing Medical Certificates

Ministry of Justice
Cremation guidelines

Death certification

There is no legal definition of death in the UK although guidelines exist. Current guidance states 'death should be verified by a doctor, or other suitably qualified personnel' which means staff such as nurse practitioners may verify (but not certify) death.

After a patient has died a doctor needs to complete a medical certificate of cause of death (MCCD). There is a list of circumstances in which a doctor should notify the Coroner prior to completing the MCCD.

Some specific points on completing the MCCD:

- 'old age' as 1a is only acceptable if the patient was at least 80 years of age . It can be used if certain conditions are met but is discouraged
- 'natural causes' is not acceptable
- organ failure (e.g. 'liver failure') can only be used if you specify the disease or

condition that led to the organ failure (e.g. 1b: Hepatitis C)

- abbreviations should be avoided (except HIV and AIDS*)

The family then take the MCCD to the local Registrar of Births, Deaths, and Marriages office to register the death. If the Registrar decides that the death does not need reporting to the Coroner he/she will issue:

- certificate for Burial or Cremation
- certificate of Registration of Death (for Social Security purposes)
- if requested. Copies of the Death Register (banks and insurance companies expect to see them)

If the family would like the burial to be outside of England, an Out of England Order is needed from the coroner.

*why this is I'm not sure - probably due to how well known the terms are amongst the general public

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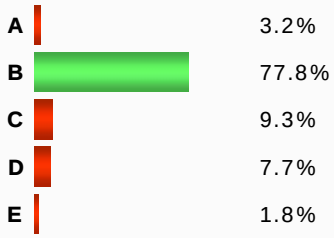
Question 58 of 93

A 38-year-old Pakistani man becomes unwell whilst visiting the UK. Which one of the following is provided to anyone, free of charge, regardless of their eligibility for NHS treatment?

- A. Surgery for a broken wrist
- ✓ B. Compulsory psychiatric treatment
- C. Outpatient treatment of HIV
- D. Angioplasty for acute myocardial infarction
- E. Medication for hypothyroidism

Next question

Question stats



77.8% of users answered this question correctly

Session score = 19%

NHS treatment eligibility

Primary care

People are eligible for primary care if they are 'ordinarily resident' in the UK. Contrary to popular belief it is not related to National Insurance contributions or nationality. This generally means they will be in the UK for at least 6 months but it should be noted that there is no qualifying period (i.e. People are entitled to care if they expect to be in the UK for 6 months). This would exclude people who have emigrated but return every so often for free NHS care. Refugees are regarded as ordinarily resident.

Secondary care

The following hospital treatment is free of charge for everyone who needs it, regardless of how long they have been or intend to stay in the UK:

- contraception
- accident and emergency department treatment (excludes emergency treatment given elsewhere in the hospital)
- compulsory psychiatric treatment
- treatment for certain communicable diseases, e.g. Tuberculosis, malaria and meningitis. Testing for HIV is free of charge, but any subsequent treatment may have to be paid for

Visitors can receive NHS hospital treatment free of charge if the need for treatment
arose during their visit to the UK and:

- person is a national of an European Economic Area (EEA) country* or Switzerland
- person normally lives abroad, and is receiving a UK state pension, and has lived in the UK in the past for at least ten years
- person has lived in the UK for at least ten years in the past, but now lives in an EEA state, or in a non-EEA state with which the UK has a reciprocal

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

External links

Department of Health
Eligibility for free hospital treatment under the NHS

agreement
- person is a national, or a resident of certain non-EEA countries, with which the UK has a reciprocal agreement.

*European Union countries plus Liechtenstein, Iceland and Norway

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Next question

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Question 59 of 93

Which one of the following statements regarding the Delphi method is correct?

- A. There should be at least five rounds
- B. It is preferable if the panel size is less than 10
- ✓ C. One of the key features is the anonymity of the participants
- D. The panel should meet after each round to discuss the findings
- E. Is not a suitable method for developing evidenced-based guidelines

Next question

There is no reason why the size of the panel should be limited, other than resource limitations. It has been suggested that the minimum number of people should be seven.

Delphi process

A Delphi process (also known as the Delphi method or technique) is a structured way of collecting and distilling the knowledge from a group of experts, often about issues where there is little formal evidence.

It consists of a number of 'rounds' of questionnaires. The first round tends to ask the experts a number of broad questions. The results of the first round are then sorted and common themes are distilled down. This information then goes on to form the second, more specific, questionnaire which again is sent out to the panel of experts. This iterative process is usually repeat two or three times.

Examples of where the Delphi method may be used:

- curriculum development: i.e. Involving a range of expert stakeholders in finding out what they feel should be included
- guideline development: the expert panel may include doctors, nurses, pharmacists and patients
- forecasting future health problems

One of the key features of a Delphi process is the anonymity of the participants. This prevents individual participants from dominating the opinion forming process.

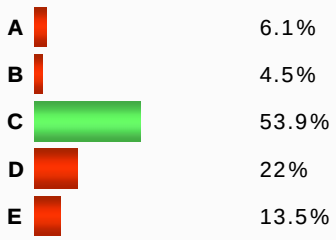
Please see the link for an excellent review by Dr Thangaramtinum and Mr Redman.

Rate question:

Next question

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Question stats



53.9% of users answered this question correctly

Session score = 18.6%

RCGP curriculum

3.6 - Research and Academic Activity

Curriculum statement

External links

RCOG
The Delphi technique

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Question 60 of 93

A 15-year-old boy sustains an undisplaced fracture of his tibial shaft whilst skiing in Italy. He has a cast applied and is discharged. The flight time home is approximately 3 hours. How soon can he fly home?

- A. 5 days after the cast is applied
- B. 7 days after the initial injury
- ✓ C. 48 hours after the cast is applied
- D. 24 hours after the cast is applied
- E. 72 hours after the initial injury

Next question

Question stats

A	1.5%
B	0.9%
C	74.8%
D	21.3%
E	1.5%

74.8% of users answered this question correctly

Session score = 18.3%

Fitness to fly

The Civil Aviation Authority (CAA) has issued guidelines on air travel for people with medical conditions; please see the link provided.

Cardiovascular disease

- unstable angina, uncontrolled hypertension, uncontrolled cardiac arrhythmia, decompensated heart failure, severe symptomatic valvular disease: should not fly
- uncomplicated myocardial infarction: may fly after 7-10 days
- complicated myocardial infarction: after 4-6 weeks
- coronary artery bypass graft: after 10-14 days
- percutaneous coronary intervention: after 5 days

Respiratory disease

- pneumonia: should be 'clinically improved with no residual infection'
- pneumothorax: absolute contraindication, the CAA suggest patients may travel 2 weeks after successful drainage if there is no residual air. The British Thoracic Society used to recommend not travelling by air for a period of 6 weeks but this has now been changed to 1 week post check x-ray

Pregnancy

- most airlines do not allow travel after 36 weeks for a single pregnancy and after 32 weeks for a multiple pregnancy
- most airlines require a certificate after 28 weeks confirming that the pregnancy is progressing normally

Surgery

- travel should be avoided for 10 days following abdominal surgery

External links

Civil Aviation Authority
Fitness to fly guidelines

- laparoscopic surgery: after 24 hours
- colonoscopy: after 24 hours
- following the application of a plaster cast, the majority of airlines restrict flying for 24 hours on flights of less than 2 hours or 48 hours for longer flights

Haematological disorders

- patients with a haemoglobin of greater than 8 g/dl may travel without problems (assuming there is no coexisting condition such as cardiovascular or respiratory disease)

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Next question

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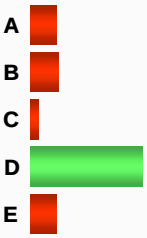
Question 61 of 93

You are advising a widow on the benefits she is entitled to following the death of her husband. What is the qualifying age range for Bereavement Allowance in this situation?

- A. If her husband was < 65 years old at the time of death
- B. If she is < 60 years old at the time of her husband's death
- C. If her husband was > 65 years old at the time of death
- ✓ D. If she is 45 - 60 years old at the time of her husband's death
- E. If her husband was 45 - 65 years old at the time of death

Next question

Question stats



56.7% of users answered this question correctly

Session score = 18%

Benefits: bereavement

Whilst GPs are not supposed to be experts on claimable benefits, a rough understanding is expected

Funeral payment	One-off payment to the partner or parent of the deceased if they are on benefits to help pay for a funeral
Bereavement payment	Lump sum given to spouse if they are under the state pension age when their partner died Depends on national insurance contributions Not payable to divorcees
Bereavement allowance	Taxable weekly benefit paid to the spouse for up to 52 weeks from the date of death, if the surviving partner is 45 years or older and less than the state pension age
Widowed Parent's Allowance	Payable to a parent whose husband or wife has died. Eligibility • surviving partner is bringing up a child < 19 years of age and receiving child benefit • deceased partner had made adequate national insurance contributions • also if the woman was expecting her late husband's baby • divorcees and those who remarry and not eligible to claim

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

External links

DirectGov
Bereavement benefits

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Next question

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Question 62 of 93

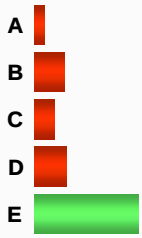
Which one of the following statements regarding the Carr-Hill formula is incorrect?

- A. Is adjusted to take account of the number of new registrations
- B. Is adjusted to take account of staff market forces
- C. Patients over the age of 85 years have the highest adjustment factor
- D. Is used to adjust the global sum total for demographic and other factors
- ✓ E. Is due to be replaced by the Jarman index

Next question

The Carr-Hill formula replaced the Jarman index, rather than the other way around

Question stats



53% of users answered this question correctly

Session score = 17.7%

GP contract: Carr-Hill formula

The Carr-Hill allocation formula is used to adjust the global sum total for a number of local demographic and other factors which may affect Practice workload. For example, a Practice with a large number of elderly patients may have a higher workload than one which primarily cares for commuters. The Carr-Hill formula replaced the Jarman index

Factors included in the Carr-Hill formula

- age and sex of patients
- nursing and residential home patients
- list turnover: adjusted for number of new registrations
- additional needs: Standardised Mortality Ratio and Standardised Long-Standing Illness for patients under the age of 65 years
- staff market forces factor
- rurality
- London weighting

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

Rate question:

Next question

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Question 63 of 93

You are a GP registrar. A mother brings her 2-year-old child into surgery. She is concerned about his frequent bouts of coughing and wheezing. Whenever the child has been seen the clinical impression has been viral-induced wheeze. Plotting his growth shows he is consistently on the 50th centile for both height and weight. It transpires that the mother is concerned about cystic fibrosis. She demands a referral to a paediatrician for further tests. Despite extensive discussions she is still concerned. What is the most appropriate action?

- A. Advise her to see one of the senior GPs for a second opinion
- B. Tell her she should pay for a private referral
- C. Politely refuse explaining it is your decision about management
- D. Remove her from the practice list
- ✓ E. Refer her to a paediatrician

Next question

Question stats

A	21.1%
B	0.2%
C	2.6%
D	0%
E	76.1%

76.1% of users answered this question correctly

Session score = 17.5%

This is a situation that requires a balanced approach. As a principle doctors are of course free to make decisions regarding management and are not obliged to follow patient requests. However, the mother clearly has concerns about her child. Such concerns should always be acknowledged and taken seriously, not least because parents know their children best and are often right.

If a mother cannot be reassured about her child then the best course of action is to refer to paediatrics. Advising her to see a colleague may be an option, particularly if the doctor has an interest in paediatrics, but is unlikely to reassure her given the concerns about cystic fibrosis.

Refusing to refer the child is likely to lead to ongoing anxiety. Telling her to pay for a private referral is a poor option as it gives the impression that the child would benefit from review but that you are not willing to do it on the NHS.

Disagreements with patients about management are not grounds for practice list removal.

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

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Rate question:

Next question

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Questions 64 to 66 of 93

Theme: DVLA: visual disorders

A Can never drive
B Consultant opinion required
C Must notify DVLA
D No driving until visual fields assessed
E Cannot drive alone
F No need to inform the DVLA

For each of the following scenarios select the most appropriate advice regarding driving a car:

64. A patient with acromegaly is found to have a degree of bitemporal hemianopia.

Can never drive

The correct answer is No driving until visual fields assessed

65. A patient who has an nucleation for an ocular tumour. The acuity and visual fields in the remaining eye are normal.

Can never drive

The correct answer is Must notify DVLA

66. A patient with blepharospasm.

Can never drive

The correct answer is Consultant opinion required

Next question

Question stats

Average score for registered users:

64	66.8%
65	50.5%
66	39.2%

Session score = 16.7%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

External links

DVLA
DVLA guidelines

DVLA: visual disorders

The guidelines below relate to car/motorcycle use unless specifically stated. For obvious reasons, the rules relating to drivers of heavy goods vehicles tend to be much stricter

Visual field defects

- driving must cease unless confirmed able to meet recommended national

guidelines for visual field

Monocular vision

- must notify DVLA
- may drive if acuity and visual field is normal in the remaining eye

Blepharospasm

- consultant opinion is required

Rate question:

Next question

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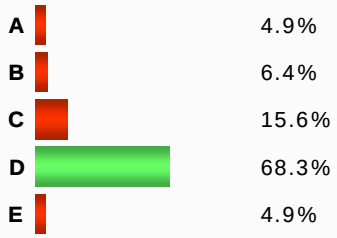
Question 67 of 93

Which one of the following statements regarding the Statement of Fitness for Work is correct?

- A. Before completing the statement there must be at least one face-to-face consultation with a doctor
- B. A small administration fee may be charged for issuing lost copies of the statement
- C. You cannot complete a note following the assessment of a Nurse Practitioner
- ✓ D. The advice you offer on returning to work may be ignored by employers
- E. Other significant past medical history should be included on the form

Next question

Question stats



68.3% of users answered this question correctly

Session score = 16.4%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

External links

Department of Work and Pensions
Statement of Fitness for Work

Statement of Fitness for Work

In 2010 sick notes became fit notes, or more formally the Statement of Fitness for Work. They have been introduced to reflect the fact that in the majority of cases patients do not need to be 100% fit before returning to work. The major change is allowing a doctor to advise that a patient 'may be fit for work taking account of the following advice'.

This information is taken from the Department of Work and Pensions website. Please see the link for further details.

Other changes

- the Statement of Fitness for Work replaces the Med3 and Med5 in one form
- the Med4, Med6 and RM 7 forms have been withdrawn due to the replacement of Incapacity Benefit with the Employment and Support Allowance
- telephone consultations are now an acceptable form of assessment
- there is no longer a box to say a patient is fit for work. There is however an option to state if you need to assess your patient's fitness for work again at the end of the statement period
- there is increased space for comments on the functional effects of the condition, including tick boxes for simple things that may help a patient back to work
- during the first 6 months of an illness the new statement can be issued for no longer than 3 months.. After this time it may be issued for an indefinite period

Things that stay the same

- can only be completed by a doctor
- you can still the advise a patient that they are not fit for work (of any type)

- the advice on the statement is not binding on employers

The statement may be issued:

- on the day that you assessed the patient
- on a date after you assessed your patient if you consider that it would have been reasonable to issue a statement on the day of the assessment
- after consideration of a written report from another doctor or registered health care professional

There are 4 'tick boxes' included on the form which represent common approaches to aid a return to work. One or more may be ticked. Other approaches can be suggested in the comments box. The options are:

- a phased return to work
- altered hours
- amended duties
- workplace adaptations

Patients may self-certify for the first 7 calendar days:

SC1	Self-certification, for patients not eligible to claim statutory sick pay (e.g. Unemployed or self-employed). For the first 7 calendar days of an illness
SC2	The 'standard' self-certification form, for patients eligible to claim statutory sick pay. For the first 7 calendar days of an illness

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Question 68 of 93

You issue a prescription for oxycodone for a patient with severe chronic lower back pain. How long is the prescription valid for?

- A. 6 months
- B. 7 days
- C. 13 weeks
- ✓ D. 28 days
- E. 3 days

Next question

Question stats

A	5%
B	13.1%
C	2.6%
D	76.5%
E	2.9%

76.5% of users answered this question correctly

Session score = 16.2%

Controlled drugs

When prescribing a controlled drug the following must be present on the prescription:

- name and address of the patient
- the form, and where appropriate the strength, of the preparation

- either the total quantity (in both words and figures) of the preparation, or the number (in both words and figures) of dosage units to be supplied

- the dose (cannot write 'as directed')
- prescribers name, signature, address and current date

The 2001 Misuse of Drugs Regulations act defines who is authorised to prescribe controlled drugs. It divided drugs of potential abuse into 5 categories ('schedules') each with own rules on prescribing, supply, possession, record keeping etc

Schedule 1	Cannabis, lysergide
Schedule 2	Diamorphine, morphine, pethidine, amphetamine, cocaine
Schedule 3	Barbiturates, buprenorphine, midazolam*, temazepam**
Schedule 4	**Part 1**: Benzodiazepines (except midazolam and temazepam) and zolpidem **Part 2**: Androgenic and anabolic steroids, hCG, somatropin Controlled drug prescription requirements do not apply and Schedule 4 controlled drugs are not subject to safe custody requirements
Schedule 5	Includes preparations which because of their strength are exempt from the vast majority of Controlled Drug requirements other than retention of invoices (e.g. Oramorph 10mg/5ml)

RCGP curriculum

3.2 - Patient Safety

Curriculum statement

External links

UK Government
Misuse of Drugs Regulations 2001

Further selected points

- Schedule 2 and 3 drugs are marked 'CD' in the BNF
- a prescription for controlled drugs in Schedules 2,3 & 4 is valid for 28 days
- a pharmacist is generally not allowed to dispense unless all the information required by law is given. With Schedule 2 and 3 drugs a pharmacist is allowed to amend the prescription if 'it specifies the total quantity only in words or in figures or if it contains minor typographical errors, provided that such amendments are indelible and clearly attributable to the pharmacist making them'

*midazolam was changed from schedule 4 to 3 in 2008

**temazepam is excluded from the prescription requirements

Rate question:

Next question

Comment on this question

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Question 69 of 93

A 34-year-old woman presents to surgery. She is 12 weeks pregnant and requests a termination of pregnancy as she says she couldn't cope with another child. From your records she has three children aged 3, 6 and 10 years and in the past has had five previous terminations, including one at 17 weeks. In the past she has refused to use contraception due to her perceived risks of side-effects. You have in the past referred people for terminations but are troubled by the number she has had previously and her reluctance to use contraception. What is the most appropriate action?

- A. Tell her it is dangerous to have another termination and advise her not to go ahead on health grounds
- B. Advise her to see a colleague due to your reservations
- ✓ C. Refer for termination of pregnancy + arrange an appointment to discuss contraception
- D. Tell her you want no part in it but give her the details for the British Pregnancy Advisory Service
- E. Refuse to arrange the termination

Next question

Firstly it should be acknowledged that no doctor should have to participate/refer/perform a termination of pregnancy if they have ethical objections, for example on religious grounds. They do however have to refer on to another doctor who may help the patient.

In this scenario the doctor has previously referred the patients for terminations but is faced with a situation where they may feel the patient is not taking sufficient responsibility for their own health, i.e. The doctor has no ethical objection to abortion but is troubled/angered by the situation. The key to the answer is to act in a non-judgemental way – if you have referred the patient previously then the only reason you would not refer now is because you have made a judgement about the patient.

The next best option is to refer her to a colleague because of your reservations. Telling her 'you want no part in it' is unprofessional but at least you are referring her to someone who may help her. Refusing to arrange the termination is not performing your duty to help a patient and the worst option is to tell her that it is dangerous to go ahead on health grounds as this is not correct.

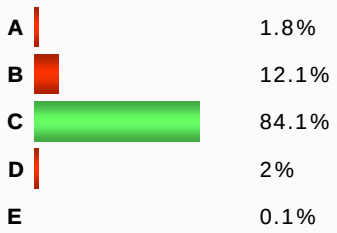
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Rate question:

Next question

Comment on this question

Question stats



84.1% of users answered this question correctly

Session score = 15.9%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

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Question 70 of 93

A patient glances at the computer screen whilst you take his blood pressure. He notices in the 'summary' section that he is listed as suffering from erectile dysfunction. The patient reports that he has never consulted a doctor regarding this and feels this could have been a misunderstanding during a consultation about depression three years ago. This seems to be confirmed when you view his previous records. What is the most appropriate course of action?

- A. Make a back-dated entry into the records clarifying his symptoms of reduced libido
- B. Keep the entry + record the patient's objection
- ✓ C. Delete the 'Erectile dysfunction' summary
- D. Contact the Information Commissioner's Office
- E. Refer to a urologist to clarify the matter

Next question

This is a factual error and should be amended.

Data Protection Act

The 1998 Data Protection Act is the main piece of legislation that governs the protection of personal data in the UK. The Act covers both manual and computerised records.

There are 8 main principles of the Data Protection Act:

- data must be used for the specific purpose it was collected
- data must not be disclosed to other parties without the consent of the individual whom it is about
- individuals have a right of access to the information held about them
- personal information may be kept for no longer than is necessary and must be kept up-to-date
- personal information may not be transmitted outside the European Union unless consent has been given
- all entities (e.g. a GP surgery) that process personal information must register with the Information Commissioner's Office
- adequate security measures must be in place. Those include technical measures (e.g. passwords, firewalls) and organisational measures (e.g. staff training)
- subjects (i.e. patients) have the right to have factually incorrect information about them corrected

Rate question:

Next question

Comment on this question

Question stats

A	9.5%
B	36.3%
C	52%
D	2%
E	0.2%

52% of users answered this question correctly

Session score = 15.7%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

External links

Information Commissioner's Office
Guidelines on recording opinions

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Question 71 of 93

A 15-year-old girl presents to surgery with her friend requesting an abortion. She has missed her last three periods and performed a pregnancy test which was positive. Her boyfriend is also 15-years-old. Due to her gestation it is likely she will require a surgical termination of pregnancy. She does not want to inform her parents. What is the most appropriate action?

- A. Respect her decision not to inform her parents, discuss her options and if she wishes refer her for a termination of pregnancy
- ✓ B. Explore why she does not want her parents to know, discuss her options and if she wishes refer her for a termination of pregnancy
- C. Ask her to go for a course of counselling before referring for a termination
- D. Ask the patient to wait in the waiting room whilst you phone her mother and ask her what she wants to happen
- E. Refer her for a termination of pregnancy but let her known you have a legal duty to inform her mother

Next question

As she is a minor she is able to consent to medical intervention but not able to refuse it. Regardless of her age she is still entitled to be treated confidentially.

If she goes ahead with a surgical termination of pregnancy it will require inpatient treatment and it is unlikely she would be able to keep this from her parents. It is best to gently explore this issue from the outset and this is therefore the best option. Doctors who have an ethical objection to abortion should refer her on to another doctor.

Referring her for a course of counselling will only delay an already late abortion.

As discussed previously the patient has a right to confidentiality.

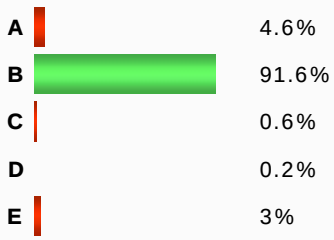
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Rate question:

Next question

Comment on this question

Question stats



91.6% of users answered this question correctly

Session score = 15.5%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

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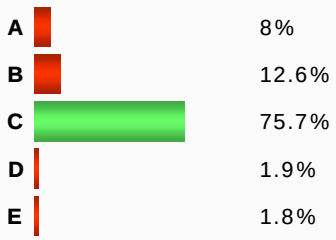
Question 72 of 93

A 65-year-old man is diagnosed as having a 5.7 cm abdominal aortic aneurysm. At what size would this disqualify him from driving?

- A. 5.5 cm (i.e. He is disqualified straight away)
- B. 6.0 cm
- ✓ C. 6.5 cm
- D. 6.7 cm
- E. 7.0 cm

Next question

Question stats



75.7% of users answered this question correctly

Session score = 15.3%

DVLA: cardiovascular disorders

The guidelines below relate to car/motorcycle use unless specifically stated. For obvious reasons, the rules relating to drivers of heavy goods vehicles tend to be much stricter

Specific rules

- angioplasty (elective) - 1 week off driving
- CABG - 4 weeks off driving
- acute coronary syndrome- 4 weeks off driving, 1 week if successfully treated by angioplasty
- angina - driving must cease if symptoms occur at rest/at the wheel
- pacemaker insertion - 1 week off driving
- implantable cardioverter-defibrillator: if implanted for sustained ventricular arrhythmia: cease driving for 6 months. If implanted prophylatically then cease driving for 1 month
- successful catheter ablation for an arrhythmia- 2 days off driving
- aortic aneurysm of 6cm or more - notify DVLA. Licensing will be permitted subject to annual review. An aortic diameter of 6.5 cm or more disqualifies patients from driving
- heart transplant: DVLA do not need to be notified

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

External links

DVLA
Cardiovascular disorder guidelines

Rate question:

Next question

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Question 73 of 93

A 62-year-old man is seen in the rapid access transient ischaemic attack clinic following three episodes over the past two weeks of transient left sided weakness. What is the most appropriate advice to give with regards to driving?

- A. Cannot drive for 12 months
- B. Cannot drive until investigations complete
- C. Inform DVLA but can continue driving
- ✓ D. Cannot drive for 3 months
- E. Cannot drive for 1 month

Next question

DVLA advice post multiple TIAs: cannot drive for 3 months

Question stats

A	3.8%
B	5%
C	0.3%
D	82.9%
E	8.1%

82.9% of users answered this question correctly

Session score = 15.1%

RCGP curriculum

15.7 - Neurological Problems

Knowledge

Curriculum statement

External links

DVLA
Neurological disorder guidelines

DVLA: neurological disorders

The guidelines below relate to car/motorcycle use unless specifically stated. For obvious reasons, the rules relating to drivers of heavy goods vehicles tend to be much stricter

Specific rules

- first seizure: 6 months off driving*. For patients with established epilepsy they must be fit free for 12 months before being able to drive
- stroke or TIA: 1 month off driving
- multiple TIAs over short period of times: 3 months off driving
- craniotomy e.g. For meningioma: 1 year off driving**
- pituitary tumour: craniotomy: 6 months; trans-sphenoidal surgery 'can drive when there is no debarring residual impairment likely to affect safe driving'
- narcolepsy/cataplexy: cease driving on diagnosis, can restart once 'satisfactory control of symptoms'

Syncope

- simple faint: no restriction
- unexplained, low risk of recurrence: 4 weeks off
- explained and treated: 4 weeks off
- unexplained: 6 months off

*previously rule was 12 months. It is now 6 months off driving if the licence holder has undergone assessment by an appropriate specialist and no relevant abnormality has been identified on investigation, for example EEG and brain scan where indicated

**if the tumour is a benign meningioma and there is no seizure history, licence can be reconsidered 6 months after surgery if remains seizure free

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Question 74 of 93

Which one of the following statements regarding Widowed Parent's Allowance is correct?

- A. Stops if the surviving parent remarries
- B. Only payable to women
- C. Is paid regardless of the deceased partner's national insurance contributions
- D. Only payable to parents on income support and receiving working families tax credits
- E. Is paid for 5 years following the death of the other partner

Next question

Question stats

A	65.1%
B	0.8%
C	16.6%
D	9.8%
E	7.7%

65.1% of users answered this question correctly

Session score = 14.9%

Benefits: bereavement

Whilst GPs are not supposed to be experts on claimable benefits, a rough understanding is expected

Funeral payment	One-off payment to the partner or parent of the deceased if they are on benefits to help pay for a funeral
Bereavement payment	Lump sum given to spouse if they are under the state pension age when their partner died Depends on national insurance contributions Not payable to divorcees
Bereavement allowance	Taxable weekly benefit paid to the spouse for up to 52 weeks from the date of death, if the surviving partner is 45 years or older and less than the state pension age
Widowed Parent's Allowance	Payable to a parent whose husband or wife has died. Eligibility • surviving partner is bringing up a child < 19 years of age and receiving child benefit • deceased partner had made adequate national insurance contributions • also if the woman was expecting her late husband's baby • divorcees and those who remarry and not eligible to claim

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

External links

DirectGov
Bereavement benefits

Rate question:

Next question

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Questions 75 to 77 of 93

Theme: DVLA: cardiovascular disorders

A No restriction
B 1 week off driving
C 2 weeks off driving
D 4 weeks off driving
E 6 weeks off driving
F 2 months off driving
G 3 months off driving
H No restriction but inform DVLA
I Inform DVLA - cannot drive

For each of the following scenarios select the most appropriate advice regarding driving a car:

75. A 54-year-old man is admitted with a ST-elevation myocardial infarction. He is successfully treated with primary angioplasty.

No restriction

The correct answer is 1 week off driving

76. A man is found to have an abdominal aortic aneurysm of 6.6cm during routine screening.

No restriction

The correct answer is Inform DVLA - cannot drive

77. A 20-year-old man who had a successful cardiac transplant six months ago following an episode of viral cardiomyopathy.

No restriction

Next question

Question stats

Average score for registered users:

75	67.3%
76	85.4%
77	58.6%

Session score = 15.6%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

External links

DVLA
Cardiovascular disorder guidelines

DVLA: cardiovascular disorders

The guidelines below relate to car/motorcycle use unless specifically stated. For obvious reasons, the rules relating to drivers of heavy goods vehicles tend to be

much stricter

Specific rules

- angioplasty (elective) - 1 week off driving
- CABG - 4 weeks off driving
- acute coronary syndrome- 4 weeks off driving, 1 week if successfully treated by angioplasty
- angina - driving must cease if symptoms occur at rest/at the wheel
- pacemaker insertion - 1 week off driving
- implantable cardioverter-defibrillator: if implanted for sustained ventricular arrhythmia: cease driving for 6 months. If implanted prophylatically then cease driving for 1 month
- successful catheter ablation for an arrhythmia- 2 days off driving
- aortic aneurysm of 6cm or more - notify DVLA. Licensing will be permitted subject to annual review. An aortic diameter of 6.5 cm or more disqualifies patients from driving
- heart transplant: DVLA do not need to be notified

Rate question:

Next question

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Question 78 of 93

The next patient you see is a 27-year-old ST1 doctor in anaesthetics. His asthma is poorly controlled at the moment. He mentions in passing that he smokes cannabis. What is the most appropriate action?

- A. Tell him that unless he stops you will have to inform the hospital he works for
- B. Don't mention his cannabis smoking
- C. Phone the police
- D. Phone the clinical director of anaesthetics to inform him/her
- ✓ E. Discuss the potential negative effects of smoking cannabis

Next question

There is no indication from the scenario that the actions of the doctor are adversely affecting his work as an anaesthetist. A doctor has come to you as a patient for medical care.

Phoning the clinical director, or threatening to phone the hospital, are poor options as this breaks confidentiality without just grounds. Whilst smoking cannabis is illegal this is not a matter that should be referred to the police.

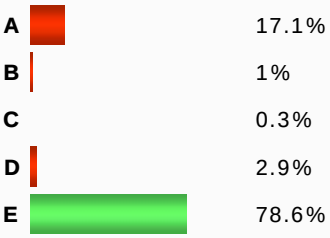
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Rate question:

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Comment on this question

Question stats



78.6% of users answered this question correctly

Session score = 15.4%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

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Question 79 of 93

A 45-year-old Polish man comes in to surgery with his 19-year-old daughter. She describes him becoming increasingly withdrawn over the past few weeks and is worried he may be depressed. He speaks very limited English but his daughter is fluent. What is the most appropriate action?

- A. Arrange a consultation for tomorrow using the translation telephone service to get the full history
- B. Use his daughter to act as an interpreter
- C. Use diagrams and body language to elicit the history
- D. Use 'Google Translate', taking it in turns to enter the text
- ✓ E. Arrange an appointment as soon as you can get an interpreter

Next question

This scenario is increasingly common in the UK due to migration patterns of the past decade.

The best response is to get an interpreter in to surgery. Discussing depressive symptoms will be difficulty over the phone. Using his daughter is a poor option as his depression may relate to family problems.

Computer translation services such as Google Translate are not sufficiently accurate to ensure the nuances of his symptoms are understood

Diagrams and body language will not adequately elicit a depression history.

_

Rate question:

Next question

Comment on this question

Question stats

A	26.3%
B	16.9%
C	0.4%
D	0.4%
E	56.1%

56.1% of users answered this question correctly

Session score = 15.2%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

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Question 80 of 93

In the National Health Service, which body commissions acute hospital trusts?

- A. Primary Care Trusts
- B. Strategic Health Authorities
- C. Local GP practices
- D. NHS Foundation Trusts
- E. Department of Health

Next question

Question stats

A	45.9%
B	24.3%
C	0.8%
D	16.3%
E	12.6%

45.9% of users answered this question correctly

Session score = 15%

NHS structure

A simplified structure of the NHS in England is presented below:

- Department of Health, is responsible for:
- 10 Strategic Health Authorities, who are responsible for:
- 150 Primary Care Trusts

The Primary Care Trusts commission services from the following providers:

- primary care services: usually independent contractors such as GP practices, dental practices
- acute hospital trusts and NHS foundation trusts
- mental health trusts
- ambulance trusts
- community health services (e.g. District nursing, health visitors)

In Scotland there are 14 area Health Boards rather than Trusts. In Wales there are 22 Local Health Boards. The system in Northern Ireland is currently in the process of change

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

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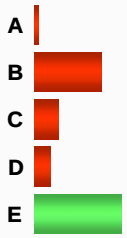
Question 81 of 93

The prescription of controlled drugs are regulated by the 2001 Misuse of Drugs Regulations act. How is Oramorph 10mg/5ml classified?

- A. Schedule 1
- B. Schedule 2
- C. Schedule 3
- D. Schedule 4
- E. Schedule 5 ✓

Next question

Question stats



44.4% of users answered this question correctly

Session score = 14.8%

Controlled drugs

When prescribing a controlled drug the following must be present on the prescription:

- name and address of the patient
- the form, and where appropriate the strength, of the preparation

- either the total quantity (in both words and figures) of the preparation, or the number (in both words and figures) of dosage units to be supplied

- the dose (cannot write 'as directed')
- prescribers name, signature, address and current date

The 2001 Misuse of Drugs Regulations act defines who is authorised to prescribe controlled drugs. It divided drugs of potential abuse into 5 categories ('schedules') each with own rules on prescribing, supply, possession, record keeping etc

Schedule 1	Cannabis, lysergide
Schedule 2	Diamorphine, morphine, pethidine, amphetamine, cocaine
Schedule 3	Barbiturates, buprenorphine, midazolam*, temazepam**
Schedule 4	**Part 1**: Benzodiazepines (except midazolam and temazepam) and zolpidem **Part 2**: Androgenic and anabolic steroids, hCG, somatropin Controlled drug prescription requirements do not apply and Schedule 4 controlled drugs are not subject to safe custody requirements
Schedule 5	Includes preparations which because of their strength are exempt from the vast majority of Controlled Drug requirements other than retention of invoices (e.g. Oramorph 10mg/5ml)

RCGP curriculum

3.2 - Patient Safety

Curriculum statement

External links

UK Government
Misuse of Drugs Regulations 2001

Further selected points

- Schedule 2 and 3 drugs are marked 'CD' in the BNF
- a prescription for controlled drugs in Schedules 2,3 & 4 is valid for 28 days
- a pharmacist is generally not allowed to dispense unless all the information required by law is given. With Schedule 2 and 3 drugs a pharmacist is allowed to amend the prescription if 'it specifies the total quantity only in words or in figures or if it contains minor typographical errors, provided that such amendments are indelible and clearly attributable to the pharmacist making them'

*midazolam was changed from schedule 4 to 3 in 2008

**temazepam is excluded from the prescription requirements

Rate question:

Next question

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Question 82 of 93

You are a GP registrar and review a 23-year-old who presented with headache, muscle aches and fever. On examination she has a temperature of 38.3ºC and complains of some neck and back pains. You feel the most likely diagnosis is influenza but are concerned about the possibility of meningitis given the neck pain. On phoning the hospital you speak to the medical registrar who feels that the presentation sounds very much like the flu and doesn't think admission is necessary. On asking the registrar to accept the patient he refuses, tells you he's got to go as he is so busy and puts the phone down. What is the most appropriate course of action?

- A. Bleep the registrar again, demand his GMC number and threaten to make a complaint if he does not accept the patient
- ✓ B. Phone the medical consultant on-call and explain your concerns
- C. Tell the patient to go to A&E herself with a written letter explaining the situation
- D. Respect the opinion of the registrar and monitor the patient at home
- E. Tell the patient to go to A&E herself but avoid writing a letter so as not to offend the admitting medical team

Next question

Whilst the tempting thing is to have a row with the medical registrar this scenario looks for a more professional approach. Whilst it is true that the most likely cause for the patients' symptoms is influenza it is not unreasonable to want to exclude meningitis.

The best course of action is to try and reason with the registrar but if this fails the consultant on-call should be spoken to. They after all are in charge of the admitting medical team. As you have concerns about the patient it is important that they are seen in secondary care. It is therefore reasonable to send the patient to A&E for assessment, and more professional to give the patient a letter explaining the situation.

It is clear from the scenario that the medical registrar has not made an appropriate assessment of the patient. As you have concerns it is therefore a poor option to monitor the patient at home.

Taking a confrontational approach with the medical registrar is unlikely to result in resolution of the situation and risks getting in the way of patient care.

_

Rate question:

Next question

Comment on this question

Question stats

A	0.4%
B	83.2%
C	14.2%
D	1.9%
E	0.3%

83.2% of users answered this question correctly

Session score = 14.6%

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4.1 - Management in Primary Care

Curriculum statement

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Question 83 of 93

A 30-year-old woman with a history of menorrhagia asks for advice. She is about fly from London to New York for a holiday. Her last haemoglobin was 9.8 g/dl. According to Civil Aviation Authority guidelines, what is the lowest haemoglobin this patient can fly with?

- A. 9 g/dl
- B. 10 g/dl
- C. 7 g/dl
- D. 11 g/dl
- ✓ E. 8 g/dl

Next question

Question stats

A	6.9%
B	1.8%
C	4.8%
D	0.3%
E	86.2%

86.2% of users answered this question correctly

Session score = 14.5%

Fitness to fly

The Civil Aviation Authority (CAA) has issued guidelines on air travel for people with medical conditions; please see the link provided.

Cardiovascular disease

- unstable angina, uncontrolled hypertension, uncontrolled cardiac arrhythmia, decompensated heart failure, severe symptomatic valvular disease: should not fly
- uncomplicated myocardial infarction: may fly after 7-10 days
- complicated myocardial infarction: after 4-6 weeks
- coronary artery bypass graft: after 10-14 days
- percutaneous coronary intervention: after 5 days

Respiratory disease

- pneumonia: should be 'clinically improved with no residual infection'
- pneumothorax: absolute contraindication, the CAA suggest patients may travel 2 weeks after successful drainage if there is no residual air. The British Thoracic Society used to recommend not travelling by air for a period of 6 weeks but this has now been changed to 1 week post check x-ray

Pregnancy

- most airlines do not allow travel after 36 weeks for a single pregnancy and after 32 weeks for a multiple pregnancy
- most airlines require a certificate after 28 weeks confirming that the pregnancy is progressing normally

Surgery

External links

Civil Aviation Authority
Fitness to fly guidelines

- travel should be avoided for 10 days following abdominal surgery
- laparoscopic surgery: after 24 hours
- colonoscopy: after 24 hours
- following the application of a plaster cast, the majority of airlines restrict flying for 24 hours on flights of less than 2 hours or 48 hours for longer flights

Haematological disorders

- patients with a haemoglobin of greater than 8 g/dl may travel without problems (assuming there is no coexisting condition such as cardiovascular or respiratory disease)

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Next question

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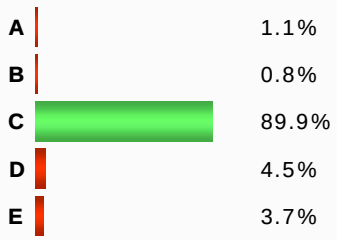
Question 84 of 93

Which one of the following statements regarding the reporting of medication related adverse events using the Yellow Card scheme is correct?

- A. A persistent cough secondary to ramipril should be reported
- B. A patient who dies of a myocardial infarction four years after starting a statin should be reported
- ✓ C. Diarrhoea occurring after starting a black triangle medicine should be reported
- D. There is no need to report a rash secondary to lymecycline in a 14-year-old girl
- E. An allergic rash that develops in an elderly man secondary to co-amoxiclav should be reported

Next question

Question stats



89.9% of users answered this question correctly

Session score = 14.3%

Yellow Card scheme

The Yellow Card scheme has become the standard way to report adverse reactions to medications. It is run by the Medicines and Healthcare products Regulatory Agency (MHRA).

The following should be reported (taken from the MHRA website)

- all suspected adverse drug reactions for new medicines (identified by the black triangle symbol) should be reported
- all suspected adverse drug reactions occurring in children, even if a medicine

has been used off-label

- all serious* suspected adverse drug reactions for established vaccines and

medicines, including unlicensed medicines, herbal remedies, and medicines used off-label

Other information

- Yellow Cards are found at the back of the BNF or reports can be completed online (www.yellowcard.gov.uk)
- any suspected reactions (not just confirmed) should be reported
- patients can report adverse events
- Yellow Cards are sent to the MHRA who in collate and assess the information. In turn the MHRA may consult with the Commission on Human Medicines (CHM), an independent scientific advisory body on medicines safety

*reactions which are fatal, life-threatening, disabling or incapacitating, result in or

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3.2 - Patient Safety

Curriculum statement

External links

MHRA
Yellow Card scheme

prolong hospitalisation, or medically significant are considered serious.

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Question 85 of 93

Which one of the following drugs should be prescribed using the proprietary, rather than the generic name?

- A. Mesalazine ✓
- B. Betahistine
- C. Cabergoline
- D. Azathioprine
- E. Sulfasalazine

Next question

Question stats

A	56.1%
B	3.4%
C	20%
D	10.2%
E	10.2%

56.1% of users answered this question correctly

Session score = 14.1%

Prescribing guidance

The BNF issues guidance on good practice when prescribing, selected points include:

- drugs should generally be prescribed by their generic name, except for certain preparations where the clinical effect may differ - please see the list below
- when writing numbers unnecessary decimal points should be avoided e.g. 250 ml not 0.25 l

Drugs which should be prescribed by brand

- modified release calcium channel blockers
- antiepileptics
- ciclosporin and tacrolimus
- mesalazine
- lithium
- aminophylline and theophylline
- methylphenidate
- CFC-free formulations of beclometasone
- dry powder inhaler devices

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Questions 86 to 88 of 93

Theme: Scoring systems used in medicine

A HAD
B PHQ-9
C Smith scale
D MMSE
E Machin classification
F Child-Pugh classification
G APGAR
H Baxter score
I CURB-65
J Epworth scale

For each of the following please select the appropriate scoring system:

Question stats

Average score for registered users:

86 93.1%
87 85.1%
88 96.6%

Session score = 14.8%

86. Can be used to evaluate the anxiety level of a patient

HAD

PHQ-9 only assess depressive symptoms.

87. A scoring system used to assess the severity of liver cirrhosis

HAD

The correct answer is Child-Pugh classification

88. Assesses the health of a newborn immediately after birth

HAD

The correct answer is APGAR

Next question

Scoring systems

There are now numerous scoring systems used in medicine. The table below lists some of the more common ones:

CHADS2	Used to determine the need to anticoagulate a patient in atrial fibrillation
ABCD2	Prognostic score for risk stratifying patients who've had a suspected TIA
NYHA	Heart failure severity scale
DAS28	Measure of disease activity in rheumatoid arthritis
Child-Pugh classification	A scoring system used to assess the severity of liver cirrhosis
Wells score	Helps estimate the risk of a patient having a deep vein thrombosis
MMSE	Mini-mental state examination - used to assess cognitive impairment
HAD	Hospital Anxiety and Depression (HAD) scale - assesses severity of anxiety and depression symptoms
PHQ-9	Patient Health Questionnaire - assesses severity of depression symptoms
GAD-7	Used as a screening tool and severity measure for generalised anxiety disorder
Edinburgh Postnatal Depression Score	Used to screen for postnatal depression
SCOFF	Questionnaire used to detect eating disorders and aid treatment
AUDIT	Alcohol screening tool
CAGE	Alcohol screening tool
FAST	Alcohol screening tool
CURB-65	Used to assess the prognosis of a patient with pneumonia
Epworth Sleepiness Scale	Used in the assessment of suspected obstructive sleep apnoea
IPSS	International prostate symptom score
Gleason score	Indicates prognosis in prostate cancer
APGAR	Assesses the health of a newborn immediately after birth
Bishop score	Used to help assess the whether induction of labour will be required
Waterlow score	Assesses the risk of a patient developing a pressure sore
FRAX	Risk assessment tool developed by WHO which calculates a patients 10-year risk of developing an osteoporosis related fracture

Can you think of any other commonly used scoring systems?

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Question 89 of 93

You are seeing a patient that you have known for the past 3 months who has disabling rheumatoid arthritis. At the end of the consultation she gives you a box of chocolates. What is the most appropriate response?

- A. Decline the gift advising her of your professional guideline
- B. Decline the gift and advise the patient that it was an inappropriate offer as it may be interpreted as a form of bribe
- ✓ C. Accept the gift and thank the patient for her kindness
- D. Accept the gift but declare on the practice 'gift register'
- E. Decline the gift but ask her to give the equivalent amount of money to charity

Next question

This scenario looks at whether you can apply judgement rather than answer in a knee jerk way.

A patient giving you a box of chocolates is a perfectly reasonable way for them to express thanks. There is no need to register this, given the relatively small size of the gift. Asking the patient to give an equivalent amount to charity may seem like a nice gesture but monetarises the offering.

Declining the gift will probably come across as odd and rude. Telling the patient off is even worse.

_

Rate question:

Next question

Comment on this question

Question stats

A	2.3%
B	0.2%
C	66.2%
D	31.1%
E	0.2%

66.2% of users answered this question correctly

Session score = 14.6%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

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Question 90 of 93

A 50-year-old bank clerk is seen in the diabetes clinic. He has type 2 diabetes mellitus which is currently treated with metformin. Unfortunately his glycaemic control is suboptimal. He is intolerant of sulfonylureas and thiazolidinediones and it is decided to add exenatide. What is the most appropriate action with respect of the DVLA?

- A. Inform DVLA but can continue to drive
- B. Inform DVLA, must check blood sugars before journey and at least every 2 hours
- ✓ C. No need to inform DVLA
- D. Inform DVLA, cannot drive until 4 weeks have passed without hypoglycaemic episodes
- E. Inform DVLA, cannot drive until 3 months have passed without hypoglycaemic episodes

Next question

The April 2009 AKT feedback report made specific mention of fitness to drive rules.

DVLA: diabetes mellitus

The guidelines below relate to car/motorcycle use unless specifically stated. For obvious reasons, the rules relating to drivers of heavy goods vehicles (HGVs) tend to be much stricter

Specific rules

- if on insulin then cannot hold HGV licence*
- if on insulin then patient can drive a car as long as they have hypoglycaemic awareness and no relevant visual impairment
- if on tablets, exenatide or gliptin no need to notify DVLA
- if diet controlled alone and no relevant complications (e.g. Maculopathy) then no requirement to inform DVLA

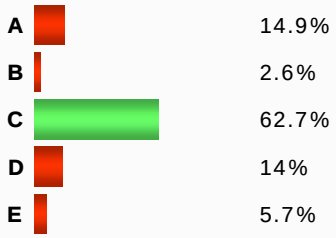
*there are complex exceptions to this rule, but these are not relevant for the purposes of the exam

Rate question:

Next question

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Question stats



62.7% of users answered this question correctly

Session score = 14.4%

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Curriculum statement

External links

DVLA
Diabetes mellitus guidelines

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Question 91 of 93

Please review the death certificate below:

1a	Congestive cardiac failure
1b	Essential hypertension
1c	
2	Old age, type 2 diabetes mellitus

Which one of the statements regarding this certificate is correct?

- A. Type 2 diabetes mellitus should have been recorded in 1c
- B. It is unacceptable to put a type of organ failure in section 1a
- C. Congestive cardiac failure is the underlying cause of death
- D. Old age should not be recorded in section 2
- ✓ E. Congestive cardiac failure is the direct cause of death

Next question

Using a type of organ failure in 1a is acceptable if the underlying cause is stated. Type 2 diabetes mellitus does not lead to essential hypertension and therefore should be recorded in section 2.

Death certification

There is no legal definition of death in the UK although guidelines exist. Current guidance states 'death should be verified by a doctor, or other suitably qualified personnel' which means staff such as nurse practitioners may verify (but not certify) death.

After a patient has died a doctor needs to complete a medical certificate of cause of death (MCCD). There is a list of circumstances in which a doctor should notify the Coroner prior to completing the MCCD.

Some specific points on completing the MCCD:

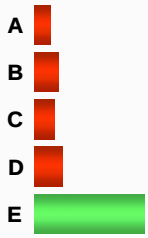
- 'old age' as 1a is only acceptable if the patient was at least 80 years of age . It can be used if certain conditions are met but is discouraged
- 'natural causes' is not acceptable
- organ failure (e.g. 'liver failure') can only be used if you specify the disease or

condition that led to the organ failure (e.g. 1b: Hepatitis C)

- abbreviations should be avoided (except HIV and AIDS*)

The family then take the MCCD to the local Registrar of Births, Deaths, and Marriages office to register the death. If the Registrar decides that the death does

Question stats



56.3% of users answered this question correctly

Session score = 14.3%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

External links

Home Office
Guidance for doctors completing Medical Certificates

Ministry of Justice
Cremation guidelines

not need reporting to the Coroner he/she will issue:

- certificate for Burial or Cremation
- certificate of Registration of Death (for Social Security purposes)
- if requested. Copies of the Death Register (banks and insurance companies expect to see them)

If the family would like the burial to be outside of England, an Out of England Order is needed from the coroner.

*why this is I'm not sure - probably due to how well known the terms are amongst the general public

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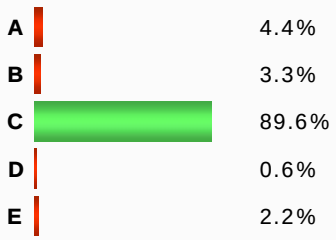
Question 92 of 93

Which one of the following is a valid reason for exception reporting a patient under the quality and outcomes framework (QOF)?

- A. A patient who has spent more than 3 months in the past 12 months in hospital
- B. A child who is being treat for acute lymphoblastic leukaemia who has coexistent asthma
- ✓ C. A patient who is on the maximum tolerated doses of medication whose treatment remains sub-optimal
- D. A patient with localised prostate cancer who has hypertension
- E. A patient who is caring for a relative who is terminally ill

Next question

Question stats



89.6% of users answered this question correctly

Session score = 14.1%

Quality and Outcomes Framework

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

The Quality and Outcomes Framework (QOF) is the annual reward and incentive programme detailing GP practice achievement results. It was introduced as part of the new General Medical Services (GMS) to incentivise not only the management of chronic disease such as diabetes but also to improve the organisation of the practice and patient experience

Other points

- for clinical indicators the value of a point is determined by the prevalence of that condition in the practice
- participation in the QOF is voluntary
- 5% of practices should be visited at random to help prevent fraud. The PCT visiting team will normally consist of a PCT management representative, a GP and a patient representative

The table below shows the four key areas on which the QOF is based

Clinical indicators	697 points	Standards linked to the care of patients suffering from chronic diseases
Organisational	167.5 points	Standards relating to records and information, communicating with patients, education and training, medicines management and clinical and practice management
Additional services	44 points	Covering cervical screening, child health surveillance, maternity services and contraceptive services
Patient experience	91.5 points	Based on patient surveys and length of consultations

Patients may be 'exception reported' in the following situations:

- patients who have been recorded as refusing to attend review who have been invited on at least three occasions during the preceding 12 months
- patients for whom it is not appropriate to review the chronic disease parameters due to particular circumstances e.g. Terminal illness, extreme frailty
- patients newly diagnosed within the practice or who have recently registered with the practice, who should have measurements made within 3 months and delivery of clinical standards within 9 months e.g. Blood pressure or cholesterol measurements within target levels
- patients who are on maximum tolerated doses of medication whose treatment remain sub-optimal
- patients for whom prescribing a medication is not clinically appropriate e.g. Those who have an allergy, another contraindication or have experienced an adverse reaction
- where a patient has not tolerated medication
- where a patient does not agree to investigation or treatment (informed dissent), and this has been recorded in their medical records
- where the patient has a supervening condition which makes treatment of their condition inappropriate e.g. Cholesterol reduction where the patient has liver disease
- where an investigative service or secondary care service is unavailable

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Question 93 of 93

During a practice meeting the partners ask you to prescribe Ventolin by brand instead of salbutamol as it is currently cheaper. What is the most appropriate response?

- A. Speak to your postgraduate dean as you are being pressured to prescribe inappropriately
- B. Give patients a choice
- ✓ C. Accept the request as it seems reasonable
- D. Tell the partners that you refuse as it is bad practice to prescribe by brand
- E. Contact the GMC

End session

Such scenarios are becoming increasingly common in the NHS. Of course during our training we are taught to prescribe generically when possible. One of the main reasons for this is to help limit costs for the NHS. Whilst it may seem ridiculous that branded preparations are cheaper than generic ones this is not uncommon anymore. It therefore seems to reasonable to prescribe Ventolin by brand.

Giving patients a choice may be an option but is likely to confuse the message that generic drugs are the same, regardless of manufacturer.

Whether patients who are used to taking a generic version of salbutamol should automatically be changed to Ventolin is another question.

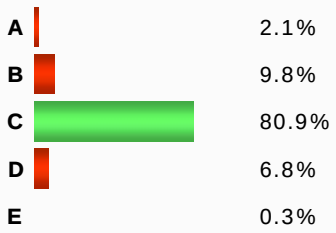
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Rate question:

End session

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Question stats



80.9% of users answered this question correctly

Session score = 14%

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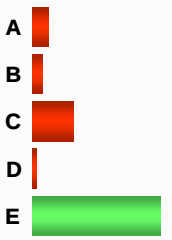
Question 2 of 184

Which one of the following products is 'blacklisted' under Part XVIIIA of the Drug Tariff and hence cannot be dispensed on the NHS?

- A. Juvela gluten-free bread
- B. Clozapine
- C. Farley's Soya Formula
- D. EpiPen
- ✓ E. Topical minoxidil

Next question

Question stats



64.9% of users answered this question correctly

Session score = 50%

Part XVIIIA of the Drug Tariff - The Blacklist

Theoretically any food, drug, toiletry or cosmetic may be prescribed on an NHS prescription unless the product is listed in Part XVIIIA of the Drug Tariff ('the blacklist').

Medical devices (appliances) can only be prescribed on NHS prescriptions if the product is listed in Part IX of the Drug Tariff.

If a proprietary product is listed in 'the blacklist', it cannot be dispensed on the NHS. The only exception to this is if the prescription is issued using a generic name and the generic name is not itself included in the blacklist.

Some examples of 'blacklisted' products:

- Propecia (finasteride for male-pattern alopecia)
- Regaine (topical minoxidil for male-pattern alopecia)
- Calpol (see above, paracetamol suspension may be prescribed)

The Selected List

Part XVIIIB of the Drug Tariff lists items that may only be prescribed for the patient groups and for the purpose listed in the Drug Tariff. Prescribers must endorse prescriptions for these products 'SLS'. This section covers the prescription of phosphodiesterase type-5 inhibitors.

For example:

- Niferex Elixir 30ml Paediatric Dropper Bottle - infants born prematurely - prophylaxis in treatment of iron deficiency
- sildenafil - only if treated prior to September 1998 or if has one of the following conditions: diabetes mellitus, Parkinson's disease, poliomyelitis, multiple, sclerosis, prostate cancer, severe pelvic injury, single gene neurological disease, spina bifida, spinal cord injury, renal failure treated with dialysis or transplant, prostatectomy or radical pelvic surgery

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4.1 - Management in Primary Care

Curriculum statement

External links

NHS
Electronic Drug Tariff

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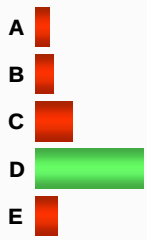
Question 3 of 184

Which one of the following would not justify removal from the practice list?

- A. A patient who has made a racially abuse comment to a member of staff whilst drunk
- B. A patient who has moved out of the catchment area
- C. A patient who refuses to confine their dog on the request of a GP during a home visit
- ✓ D. A patient who refuses to respond to any form of communication from the practice
- E. A patient who has been shown to have lied about a recent hospital admission to obtain a sick note

Next question

Question stats



55.1% of users answered this question correctly

Session score = 33.3%

Removing patients from the practice list

The following is based on the 2004 Royal College guidelines.

Examples of situations that may justify removal:

- unacceptable behaviour: for example violence, sexual harassment, stalking, racial abuse
- crime and deception: for example fraudulently obtaining drugs, stealing from the practice
- distance: a patient moves outside the catchment area

Examples of situations that do not normally justify removal:

- clinical matters:? patient choice, for example refusing to attend for health screening or not bringing their child for immunisations
- critical questioning and/or complaints

Removal is never justified in the following situations

- where there is an exacting or highly dependent patient, condition or disability
- patients with a high levels of anxiety or demand about perceived symptoms
- due to age, gender, ethnic origin, religion or sexual orientation

Further guidance is given on exceptional situations where there is an 'irretrievable breakdown' in the doctor-patient relationship. It is important that a formal process is agreed to try and rectify this problem rather than unilaterally declaring an irretrievable breakdown without giving any reasons to the patient.

Removing a patient from the practice list involves the following steps:

- give warning to the patient

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

External links

RCGP
Removing patients from the practice list guidelines

- inform the Primary Care Trust in writing
- write to the patient

The patient's family should not be automatically removed although in practice this may be necessary.

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Question 4 of 184

A mother whose 14-year-old daughter had a history of glue ear when younger asks the practice manager for a copy of her medical records. Which one of the following statements governing access to medical records is incorrect?

- A. Doctors should withhold information they may feel is damaging to the patients physical or mental health
- B. Access to records should always be given within 40 days
- C. Parents may request access to their children's records
- D. Competent children may seek access to their records
- ✓ E. Should be done without a fee

Next question

A fee is normally charged for access to medical records

Access to medical records

A patients right to view their own medical records is governed by the 1998 Data Protection Act and the 1990 Access to Health Records Act

Key principles

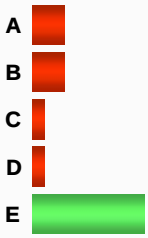
- patients have a right to see what is written in their medical record
- competent children may seek access to their records
- parents may request access to their children's (< 16 years) records
- doctors should not release information they feel may damage a patients emotional or physical health
- following the Data Protection Act access to medical records should be given within 40 days. This is the legal timeframe, however Department of Health policy states that access should be given within 21 days
- a fee may be charged

Rate question:

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Question stats



56.5% of users answered this question correctly

Session score = 25%

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4.1 - Management in Primary Care

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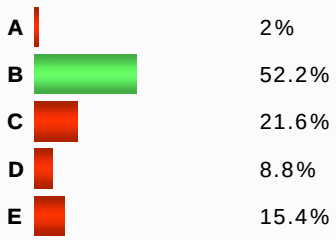
Question 5 of 184

Which one of the following situations would not automatically require a doctor to contact the coroner to discuss the death?

- A. 44-year-old man with history of depression found hanging in home
- B. 38-year-old man dies from cerebral malaria contracted in India
- C. 84-year-old nursing home resident, found dead in bed, seen 3 weeks ago by local GP
- D. 68-year-old prisoner dies following myocardial infarction
- E. 78-year-old man dies 10 hours after being admitted to local hospital with myocardial infarction

Next question

Question stats



52.2% of users answered this question correctly

Session score = 20%

Death certification: notifiable deaths

The following deaths should be reported to the coroner

- unexpected or sudden deaths
- when the doctor attending the deceased did not see them within 14 days before death
- if a death occurs within 24 hours of hospital admission
- accidents and injuries
- suicide
- industrial injury or disease (e.g. asbestosis)
- deaths occurring as a result of ill treatment, starvation or neglect
- the death occurred during an operation or before recovery from the effect of an anaesthetic
- poisoning, including taking illicit drugs
- stillbirths - if there is doubt as to whether the child was born alive
- prisoner or people in police custody
- service disability pensioners

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

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Question 6 of 184

A 54-year-old man is admitted following a myocardial infarction associated with ST elevation. He is treated with thrombolysis and does not undergo angioplasty. What advice should he be given regarding driving?

- A. Can continue driving but must inform DVLA
- B. Cannot drive until an angiogram has been performed and reviewed by a cardiologist
- C. Cannot drive for 1 week
- ✓ D. Cannot drive for 4 weeks
- E. Cannot drive for 12 weeks

Next question

DVLA advice post MI - cannot drive for 4 weeks

The April 2009 AKT feedback report made specific mention of fitness to drive rules.

DVLA: cardiovascular disorders

The guidelines below relate to car/motorcycle use unless specifically stated. For obvious reasons, the rules relating to drivers of heavy goods vehicles tend to be much stricter

Specific rules

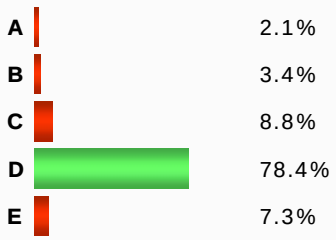
- angioplasty (elective) - 1 week off driving
- CABG - 4 weeks off driving
- acute coronary syndrome- 4 weeks off driving, 1 week if successfully treated by angioplasty
- angina - driving must cease if symptoms occur at rest/at the wheel
- pacemaker insertion - 1 week off driving
- implantable cardioverter-defibrillator: if implanted for sustained ventricular arrhythmia: cease driving for 6 months. If implanted prophylatically then cease driving for 1 month
- successful catheter ablation for an arrhythmia- 2 days off driving
- aortic aneurysm of 6cm or more - notify DVLA. Licensing will be permitted subject to annual review. An aortic diameter of 6.5 cm or more disqualifies patients from driving
- heart transplant: DVLA do not need to be notified

Rate question:

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Question stats



78.4% of users answered this question correctly

Session score = 16.7%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

External links

DVLA
Cardiovascular disorder guidelines

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Question 7 of 184

One of your patients develops a photosensitive rash after starting a newly licensed medication. You decide to complete a Yellow Card. Who is responsible for collating and assessing the Yellow Card reports?

- A. Medicines and Healthcare products Regulatory Agency (MHRA) ✓
- B. British National Formulary (BNF)
- C. Local Primary Care Trust (PCT)
- D. Commission on Human Medicines (CHM)
- E. National Patient Safety Agency (NPSA)

Next question

Question stats

A	77.2%
B	5.5%
C	1.7%
D	2.1%
E	13.4%

77.2% of users answered this question correctly

Session score = 14.3%

Yellow Card scheme

The Yellow Card scheme has become the standard way to report adverse reactions to medications. It is run by the Medicines and Healthcare products Regulatory Agency (MHRA).

The following should be reported (taken from the MHRA website)

- all suspected adverse drug reactions for new medicines (identified by the black triangle symbol) should be reported
- all suspected adverse drug reactions occurring in children, even if a medicine

has been used off-label

- all serious* suspected adverse drug reactions for established vaccines and

medicines, including unlicensed medicines, herbal remedies, and medicines used off-label

Other information

- Yellow Cards are found at the back of the BNF or reports can be completed online (www.yellowcard.gov.uk)
- any suspected reactions (not just confirmed) should be reported
- patients can report adverse events
- Yellow Cards are sent to the MHRA who in collate and assess the information. In turn the MHRA may consult with the Commission on Human Medicines (CHM), an independent scientific advisory body on medicines safety

*reactions which are fatal, life-threatening, disabling or incapacitating, result in or prolong hospitalisation, or medically significant are considered serious.

RCGP curriculum

3.2 - Patient Safety

Curriculum statement

External links

MHRA
Yellow Card scheme

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Question 8 of 184

Which one of the following statements regarding cremation forms is incorrect?

- A. Cremation 1 is the form to be completed by the patient's own GP
- B. The independent doctor who completes the form should have held a full GMC registration for more than 5 years
- C. Two doctors are required
- D. A fee is payable to each doctor
- E. Cremation 5 should be completed by an independent doctor

Next question

Cremation 1 (previously part A) is completed by the next of kin. Cremation 4 should be completed by the patient's own GP.

Question stats

A	62.2%
B	10.9%
C	3.5%
D	3.2%
E	20.1%

62.2% of users answered this question correctly

Session score = 12.5%

Cremation forms

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

Basics

- the Ministry of Justice have issued new cremation regulations which came into effect on 1st January 2009
- there is a new right of inspection of medical forms to the applicant of cremation
- 2 doctors are required to confirm both the identity and that the cause of death was not suspicious
- form B is replaced by **Cremation 4**. This should be completed by the patient's own GP or a doctor looking after them during their last illness e.g. Hospital doctors
- form C is replaced by **Cremation 5**. This should be completed by an independent doctor who must have held a full GMC registration for more than 5 years. The doctor is expected to discuss the case with the patient's GP and view the body
- the form Cremation 5 doctor cannot be a partner or work colleague of the form Cremation 4 doctor or a relative of the deceased; the two doctors must be independent of one another, i.e. Not on the same team in hospital or at the same GP surgery
- a fee is payable to each doctor

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Questions 9 to 11 of 184

Theme: Consultation models

A Heron
B Byrne and Long
C Berne
D Fraser
E Neighbour
F Balint
G Stott and Davis
H Helman's folk model
I Pendleton

For each of the following tasks select the consultation model most associated with it

9. Safety netting

Heron

The correct answer is Neighbour

10. Handing over

Heron

The correct answer is Neighbour

11. Considering other problems

Heron

The correct answer is Pendleton

Next question

Question stats

Average score for registered users:

9	68.6%
10	49.2%
11	39.3%

Session score = 9.1%

RCGP curriculum

2 - The General Practice Consultation

Curriculum statement

Consultation models

Calgary-Cambridge observation guide- Kurtz and Silverman - 1996

- initiating the session
- gathering information
- building the relationship

- giving information, explaining and planning
- closing the session

Stewart - patient-centred clinical method - 1995. 2003

- exploring both the disease and the illness experience
- understanding the whole person
- finding common ground
- incorporating prevention and health promotion
- enhancing the doctor-patient relationship
- being realistic (with time and resources)

Pendleton - The Consultation: an Approach to Learning and Teaching - 1984, 2003

- define the reason for the patient's attendance (ideas, concerns and expectations)
- consider other problems
- with the patient, choose an appropriate action for each problem
- achieve a shared understanding of the problems with the patient
- involve the patient in the management and encourage him/her to accept appropriate responsibility
- use time and resources appropriately
- establish or maintain a relationship with the patient which helps to achieve the other tasks

Fraser - Areas of competence - 1992

- interviewing and history-taking
- physical examination
- diagnosis and problem-solving
- patient management
- relating to patients
- anticipatory care
- record keeping

Neighbour - The Inner Consultation - five checkpoint model - 1987

- connecting
- summarising
- handing over
- safety netting
- housekeeping

Tuckett - meeting of two experts - 1985

- the consultation is a meeting between two experts
- doctors are experts in medicine
- patients are experts in their own illnesses
- shared understanding is the aim
- doctors should seek to understand the patient's beliefs
- doctors should address explanations in terms of the patient's belief system

Stott and Davis - Exceptional potential of the consultation - 1979

- management of presenting problems
- management of continuing problems
- modification of help-seeking behaviour
- opportunistic health promotion

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Question 12 of 184

A patient comes to surgery requesting a 'sick note'. At what point do you need to issue a Statement of Fitness for Work?

- A. After they have been off work for more than 7 calendar days ✓
- B. After they have been off work for more than 5 working days
- C. After they have been off work for more than 5 calendar days
- D. After they have been off work for more than 10 working days
- E. After they have been off work for more than 7 working days

Next question

Patients can self-cert up to 7 **calendar** days

Question stats



64.7% of users answered this question correctly

Session score = 8.3%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

External links

Department of Work and Pensions
Statement of Fitness for Work

Statement of Fitness for Work

In 2010 sick notes became fit notes, or more formally the Statement of Fitness for Work. They have been introduced to reflect the fact that in the majority of cases patients do not need to be 100% fit before returning to work. The major change is allowing a doctor to advise that a patient 'may be fit for work taking account of the following advice'.

This information is taken from the Department of Work and Pensions website. Please see the link for further details.

Other changes

- the Statement of Fitness for Work replaces the Med3 and Med5 in one form
- the Med4, Med6 and RM 7 forms have been withdrawn due to the replacement of Incapacity Benefit with the Employment and Support Allowance
- telephone consultations are now an acceptable form of assessment
- there is no longer a box to say a patient is fit for work. There is however an option to state if you need to assess your patient's fitness for work again at the end of the statement period
- there is increased space for comments on the functional effects of the condition, including tick boxes for simple things that may help a patient back to work
- during the first 6 months of an illness the new statement can be issued for no longer than 3 months.. After this time it may be issued for an indefinite period

Things that stay the same

- can only be completed by a doctor
- you can still the advise a patient that they are not fit for work (of any type)

- the advice on the statement is not binding on employers

The statement may be issued:

- on the day that you assessed the patient
- on a date after you assessed your patient if you consider that it would have been reasonable to issue a statement on the day of the assessment
- after consideration of a written report from another doctor or registered health care professional

There are 4 'tick boxes' included on the form which represent common approaches to aid a return to work. One or more may be ticked. Other approaches can be suggested in the comments box. The options are:

- a phased return to work
- altered hours
- amended duties
- workplace adaptations

Patients may self-certify for the first 7 calendar days:

SC1	Self-certification, for patients not eligible to claim statutory sick pay (e.g. Unemployed or self-employed). For the first 7 calendar days of an illness
SC2	The 'standard' self-certification form, for patients eligible to claim statutory sick pay. For the first 7 calendar days of an illness

Rate question:

Next question

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Question 13 of 184

Please review the death certificate below:

1a	Liver failure
1b	Hepatocellular carcinoma
1c	Chronic Hepatitis B infection
2	Type 2 diabetes mellitus

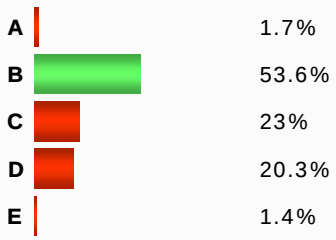
What is the underlying cause of death?

- A. Not listed on this certificate e.g. Intravenous drug use
- ✓ B. Chronic Hepatitis B infection
- C. Hepatocellular carcinoma
- D. Liver failure
- E. Type 2 diabetes mellitus

Next question

The underlying cause of death (which is important for mortality statistics) is the event in section1 which triggered the series of events which led to the death of the patient.

Question stats



53.6% of users answered this question correctly

Session score = 7.7%

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

External links

Home Office
Guidance for doctors completing Medical Certificates

Ministry of Justice
Cremation guidelines

Death certification

There is no legal definition of death in the UK although guidelines exist. Current guidance states 'death should be verified by a doctor, or other suitably qualified personnel' which means staff such as nurse practitioners may verify (but not certify) death.

After a patient has died a doctor needs to complete a medical certificate of cause of death (MCCD). There is a list of circumstances in which a doctor should notify the Coroner prior to completing the MCCD.

Some specific points on completing the MCCD:

- 'old age' as 1a is only acceptable if the patient was at least 80 years of age . It can be used if certain conditions are met but is discouraged
- 'natural causes' is not acceptable
- organ failure (e.g. 'liver failure') can only be used if you specify the disease or

condition that led to the organ failure (e.g. 1b: Hepatitis C)

- abbreviations should be avoided (except HIV and AIDS*)

The family then take the MCCD to the local Registrar of Births, Deaths, and Marriages office to register the death. If the Registrar decides that the death does

not need reporting to the Coroner he/she will issue:

- certificate for Burial or Cremation
- certificate of Registration of Death (for Social Security purposes)
- if requested. Copies of the Death Register (banks and insurance companies expect to see them)

If the family would like the burial to be outside of England, an Out of England Order is needed from the coroner.

*why this is I'm not sure - probably due to how well known the terms are amongst the general public

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Question 15 of 184

The following symbol appears in the British National Formulary:



What does it mean?

- A. Newly licensed medicine
- B. Not prescribable on the NHS
- C. Denotes a preparation that is less suitable to prescribe
- D. Should only be prescribed by a specialist
- E. Controlled drug

Next question

Question stats

A	60.1%
B	9.3%
C	10.6%
D	6.4%
E	13.6%

60.1% of users answered this question correctly

Session score = 6.7%

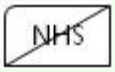
RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

British National Formulary symbols

The table below explains the meanings of the main symbols used in the BNF:

	Denotes a preparation that is less suitable to prescribe
	Newly licensed medicines
	Not prescribable on the NHS
PoM	Prescription-only medicine
CD	Controlled drug

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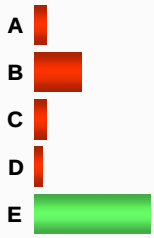
Question 1 of 2

A patient of yours is planning a holiday to France in the summer. He has arranged private travel insurance for his family but has also heard about a scheme to enable him to access state run healthcare whilst abroad. Which one of the following should you advise him about?

- A. EU20 insurance scheme
- B. E111
- C. E20 Card
- D. E110
- ✓ E. European Health Insurance Card

Next question

Question stats



58.8% of users answered this question correctly

Session score = 100%

European Health Insurance Card

The European Health Insurance Card (EHIC) entitles people to access government run healthcare in the European Economic Area and Switzerland at a reduced cost or for free. The EHIC replaced the previous E111 form in 2004.

Key points

- the EHIC is free and valid for 5 years
- it does not replace the need for private medical insurance. EHIC does fund private healthcare or provide other private insurance benefits such as search and rescue
- does not generally cover planned treatments (e.g. Varicose vein surgery) but does cover exacerbations of chronic conditions, renal dialysis and maternity care

RCGP curriculum

4.1 - Management in Primary Care

Curriculum statement

External links

NHS
European Health Insurance Card

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Question 2 of 2

Which one of the following statements regarding the European Health Insurance Card (EHIC) is correct?

- A. Covers renal dialysis
- B. Ensures all emergency treatment in the European Economic Area is free at the point of delivery
- C. Is valid for life once obtained
- D. Negates the need for private insurance whilst visiting the European Economic Area
- E. Is valid in the Channel Islands and Isle of Man

End session

Question stats

A	29.4%
B	49%
C	2.9%
D	7.8%
E	10.8%

29.4% of users answered this question correctly

Session score = 50%

European Health Insurance Card

The European Health Insurance Card (EHIC) entitles people to access government run healthcare in the European Economic Area and Switzerland at a reduced cost or for free. The EHIC replaced the previous E111 form in 2004.

Key points

- the EHIC is free and valid for 5 years
- it does not replace the need for private medical insurance. EHIC does fund private healthcare or provide other private insurance benefits such as search and rescue
- does not generally cover planned treatments (e.g. Varicose vein surgery) but does cover exacerbations of chronic conditions, renal dialysis and maternity care

RCGP curriculum

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Curriculum statement

External links

NHS
European Health Insurance Card

Rate question:

End session

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